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Auditory Issue

TABLE *of* CONTENTS

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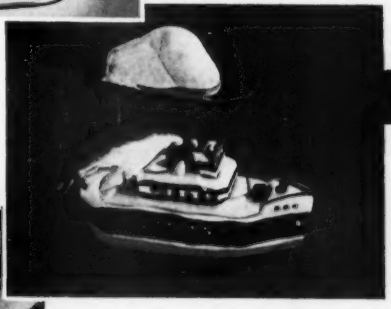

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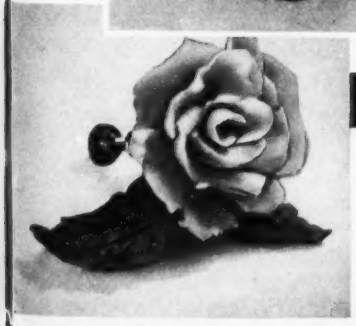

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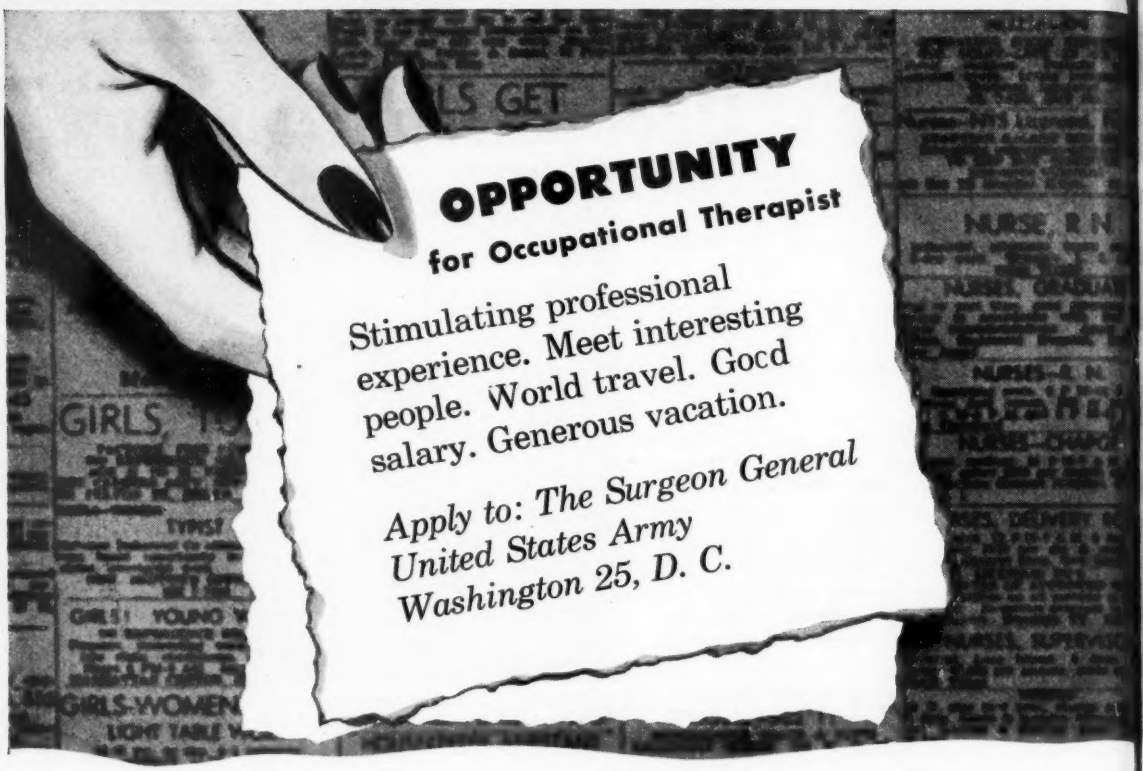

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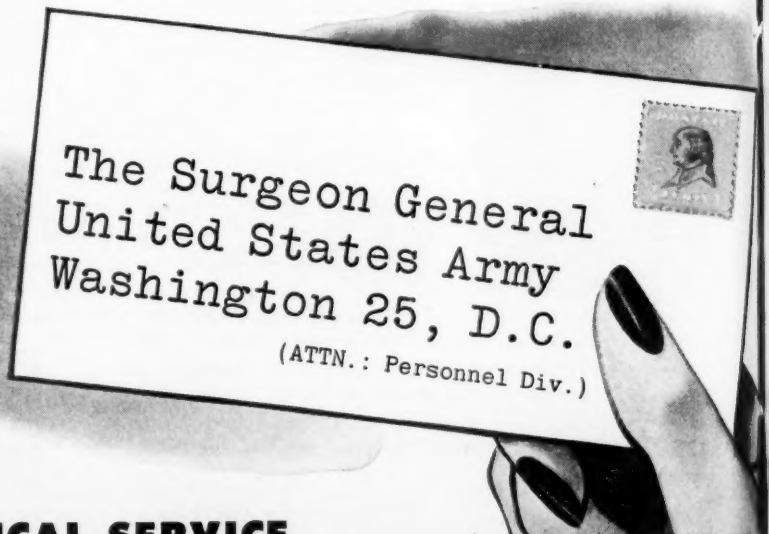

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THE AUDITORY MECHANISM AND ITS DISEASES

LOUIS KLEINFELD, M.D., F.A.C.S., F.I.C.S.

Never before has the rehabilitation of all handicapped people so keenly interested both the layman and specialist as in the present day. A wholesome and constructive attitude toward handicaps of all kinds is creating a need for excellently trained and oriented personnel to assist in the miracle of giving hope for leading normal lives to great numbers of human beings, who in former times were condemned to limitations and frustration. There is no field in which more striking accomplishment can be shown than in the education and rehabilitation of the hard of hearing, of whom there are approximately 5,000,000 in this country today. About 2,000,000 are school children and of these about 25,000 are so badly handicapped as to require training in special schools. Whether the victim of impaired hearing is a wounded veteran, an injured workman, a sufferer from a disease of the ear, or a congenitally deaf child, remarkable life-saving and life-giving help and training can be brought to him through proper handling by trained professional people in coordinated effort—doctors, teachers, psychologists, social workers and speech and occupational therapists. For the purpose of furnishing a working background of the auditory mechanism and its pathology for the rehabilitation team, this paper is presented.

ANATOMY OF THE EAR

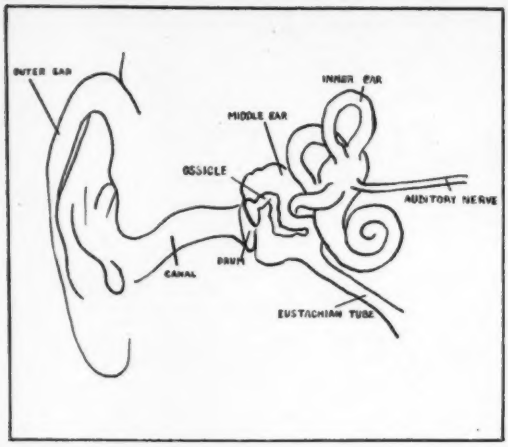
In order to understand the rationale of rehabilitation of the hard of hearing person, a knowledge of the structure and function of the auditory apparatus is essential, as well as a comprehension of the basic physics involved in the phenomenon of hearing. In addition, an understanding of the conditions that affect hearing is needed, and of course the ability to use and understand the pertinent technical nomenclature. These minimum background facts will be set forth simply here.

The sense of hearing is made possible by a mechanism which is perhaps the nearest to perfection of any human attribute. In fact, if hearing were keener than it is at present, it would defeat its own purpose, since one might hear the sounds due to the vibration of the molecules of the air. The ear can perceive sound in a tremendously wide range of intensity (the intensity of the loudest sound that can be heard is ten billion times greater than that of the lowest sound heard).

All pure sounds have pitch, duration and loudness. The loundness of ordinary conversation is about 50-60 decibels (the decibel, or *db,* is the standard unit of intensity). Many sounds have in addition to these factors, a characteristic timbre or quality, which is due, in general, to adjacent hollow resonating spaces such as the body of a piano, the box of a violin or the resonating spaces of the human skull. For example, a note of the same pitch, loudness and duration struck on a piano or on a violin can be distinguished by its characteristic quality. Groups of sounds produced in succession, as in speech or singing are also distinguished by their tempo, rhythm, modulation, inflection and range. Although the human ear is capable of perceiving sounds ranging in pitch from 20 to 20,000 vibrations per second, the range of pitch of the human voice runs only from 256 to 8192 double vibrations per second. However, a narrower range, from 512 to 4096, is adequate for understanding conversational speech. In other words, hearing losses in the 512 to 4096 range are the most incapacitating.

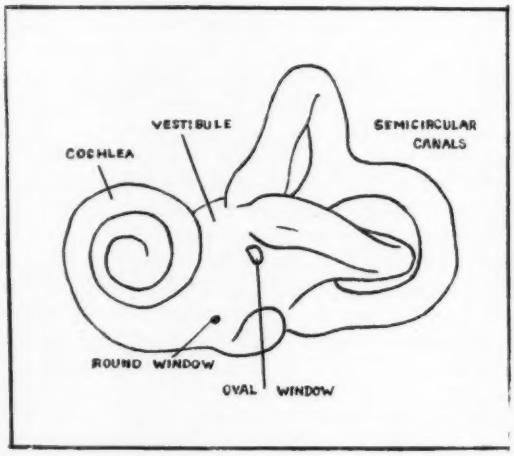
The auditory mechanism lies for the most part in that portion of the skull called the temporal bone and is generally described as consisting of an outer, a middle and an inner ear.

The outer ear (auricle or pinna) is attached to the head by six vestigal muscles. From it, a canal leads to the ear drum. This canal, called the external canal, is about 1¼" long by ⅜" in diameter and has a somewhat narrower portion called the isthmus. It is lined with skin which contains the wax-producing cerumen glands. The external canal is separated from the middle ear by the ear drum which is an oval parchment-like



Hearing Mechanism

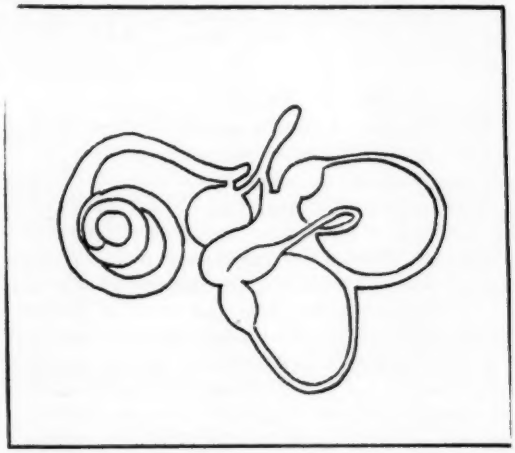
translucent membrane through which can be seen portions of the tiny bones which are contained in the middle ear. The normal position and appearance of the drum are altered by disease. For example, an abscess of the middle ear will cause the drum to bulge out, whereas a chronic catarrhal condition of the middle ear will cause a drum to be retracted or pulled inward.



Bony labyrinth (inner ear) filled with perilymph and containing the membrane labyrinth.

The middle ear is a tiny cubical space with a capacity of about 2 cubic centimeters, and which normally contains air at the same pressure as the atmospheric air. A chain of three tiny bones called ossicles, runs across the middle ear from the drum to the inner ear. These ossicles are named the malleus, incus and stapes. Their efficiency in transmitting vibrations is controlled by two very tiny muscles: the tensor tympani and the stapedius. Two nerves are present in the middle ear. Curiously, these have no function in connection with hearing, and in fact have to do with the sensation of taste (chorda tympani) and with the movement of the facial muscles (facial nerve).

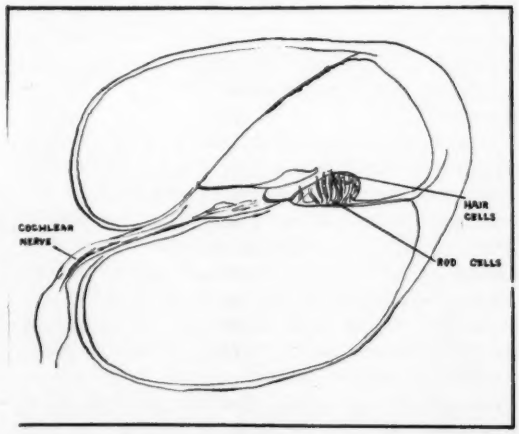
The middle ear is adjacent to various important structures so that many complications may occur as a result of middle ear infections. The structures adjacent to the middle ear are: above, the brain; below, the jugular vein; externally, the ear drum; internally, the inner ear; behind, a spongy structure called the mastoid process; and in front, the beginning of the Eustachian tube. The last named part is about 1¼" long and runs downward, forward and inward, into a space behind the nasal



Membranous labyrinth containing endolymph and lying within the bony labyrinth.

cavities and above the soft palate called the nasopharynx.

We next examine the inner ear, or labyrinth. This consists of a series of three bony canals, called the semi-circular canals, connected by a vestibular structure to a spiral coil of bone in front, called the cochlea. An opening is present in the vestibule which is known as the oval window and into



Cross section of cochlea showing organ of Corti which is the triangular section including hair and rod cells.

which the stapes fits. In the cochlea there is a round window which is filled by a tiny membrane, the inner ear drum. The bony labyrinth is filled with a fluid called perilymph in which the membranous labyrinth rests. This membranous labyrinth is a series of soft tubes filled with a fluid called endolymph. The part of this soft tube which lies within the cochlea, and which is named the scala media, contains the organ of Corti which is the essential organ of hearing. This organ consists of a series of inner and outer hair cells supported by rod cells. Tiny hairs project from the top of each hair cell. In contact with the lower surface of these cells are fibers of the auditory nerve. This nerve goes to the temporal lobe of the brain in which is the hearing center.

PHYSIOLOGY OF THE EAR

Having glanced briefly at the anatomy of the outer, middle and inner ear, we proceed to the physiology of the ear when this organ is activated.

When a sound is made it causes vibrations in the air. These air waves are scooped up by the outer ear and funneled into the external canal and carried along until they strike the ear drum which is caused to vibrate. The ossicles pick up the waves and relay them through the oval window into the perilymph (which fills the bony labyrinth). (If a sound is too loud, and the vibrations correspondingly too intense, action of the tiny muscles of the middle ear holds the ossicles in check and helps to diminish the force of the vibration and give protection to the delicate ear mechanism). When the perilymph starts to vibrate, it in turn stimulates pressure changes within the scala media (which contains the organ of Corti). This produces a bending of the hair processes of the hair cells. Whenever a hair is bent it causes a stimulation of the adjacent fibers of the 8th nerve. (Incidentally whenever a stimulus passes up the auditory nerve, the nerve of hearing, electrical currents are also produced). This stimulus is carried to the temporal lobes of the brain where it is interpreted as sound. The pitch of the sound heard depends on the location of the hair cells which are stimulated, whereas the loudness depends upon the number of hair cells thrown into vibration.

The function of the Eustachian tubes is to keep the air pressure in the middle ear the same as the pressure of the atmospheric air. This tube is normally closed and opens only when we swallow. This explains why, when we are subjected to changes of air pressure, such as in an airplane, we instinctively keep swallowing.

We must take note of the fact that although the labyrinth contains the organ of hearing, it also contains the semi-circular canals which are organs for balancing the body. This explains why some diseases of the ear are associated not only with loss of hearing but also dizzy spells.

Hearing due to the action of sound waves transmitted in the normal way through the canal and middle ear, as described above, is defined as hearing by air conduction (*AC*). However sound waves also reach the inner ear by being transmitted directly through the bones of the skull. This is called hearing by bone conduction (*BC*). Under normal circumstances, *BC* is less efficient than *AC*. In some cases of impaired hearing, however, *BC* can be very important.

It might be pertinent to add here that we are able to localize the source of sounds by the slightly different ways in which the sound vibrations hit the two ears. A person who has only one functioning ear finds it almost impossible to localize the source of a sound unless he sees it as well.

Useful in orientation to the field of hearing rehabilitation is a familiarity with the terminology found in pertinent texts and on case histories.

The term "the deaf" is usually applied to a marked and to some degree incapacitating loss of hearing sufficient to cause a person to be socially* inadequate.

"Hypacusis" is a general term covering any impairment of hearing.

"Hyperacusis" denotes abnormally keen hearing.

"Presbyacusis" refers to the more or less normal diminution of hearing that comes with age.

"Paracusis" is a peculiar distortion of hearing which causes some types of impaired hearing seemingly to improve in noisy surroundings.

"Diplacusis" is the hearing of the same tone differently in each ear.

"Tinnitus" is a purely subjective sound heard by a person within his ears, often loud enough and persistent enough to be extremely distressing. It may be due to a variety of causes including any of the conditions that affect hearing.

REASONS FOR IMPAIRED HEARING

Thus far we have described the anatomy and physiology of the ear in its normal state and functioning. We must now discuss the conditions under which hearing becomes impaired.

Generally speaking, impaired hearing may be congenital or acquired.

I. *Congenital.* Congenital deafness implies that a hearing loss is present at birth although it may not be recognized for more than a year. There are two types of congenital hearing loss: (1) *Biologic type,* the cause of which is unknown and which has a distinct hereditary tendency and (2) *Pathologic type,* which is due to some disease occurring in the mother during pregnancy (virus diseases such as German measles, Rh factor and certain drugs such as quinine). This type of congenital hearing loss is not hereditary.

*"Socially" in these definitions is used in its broadest sense.

II. *Acquired.* The conditions which lead to impaired hearing after birth can be roughly grouped according to the location within the ear of the pathological area or part.

1. In the outer canal, the only common condition which causes hearing loss is wax. (This is usually removed very easily once it is properly diagnosed).

2. Although the drum may be damaged or perforated as a result of an abscess of the middle ear, this usually causes only a minor loss of hearing.

3. The middle ear itself may be damaged by acute or chronic inflammation which may cause a considerable loss of hearing. These inflammations are usually designated by the following letters: O.M.C.A. means acute but rather mild inflammation of the middle ear. O.M.P.A. means a rather severe infection leading to an abscess of the middle ear. O.M.P.C. means a chronic discharging ear. O.M.C.C. means a chronic catarrhal inflammation without infection, leading however to fairly marked hearing impairment owing to the formation of scars in the middle ear.

4. Conditions which interfere with the functions of the Eustachian tube and thus permit abnormal air pressures in the middle ear may cause fairly marked hearing loss. The most important of these conditions is the presence of the adenoid, a spongy mass of lymphoid tissue lying in the nasopharynx and sometimes blocking the exits of the Eustachian tubes. Surgical removal of the adenoid will usually clear up this condition. If, however, tiny patches of lymphoid tissue are situated in or around the tube openings and cannot be reached surgically, they can be shrunk by means of X-ray or radium therapy. If the Eustachian tubes become blocked as a result of infections having passed up the tubes from the back of the nose, local tube treatment, including "blowing out" may be helpful. Incidentally, although the Eustachian tubes are important in aiding normal hearing, they also act as roads by which most infections travel.

In general, conditions which involve drums, outer ear, middle ear and Eustachian tubes interfere with the conduction of sound waves to the inner ear and consequently are referred to as causing "conduction deafness".

5. The inner ear can be damaged as a result of injury or infection. Since the inner ear contains the organ of Corti, any pathological condition in the inner ear can easily lead to permanent and complete loss of hearing. A fairly common disease of the inner ear is Meniere's Disease. In this condition a marked increase in pressure occurs in the endolymph, interfering with both the balancing and hearing mechanisms. Consequently, these patients show both dizzy spells and hearing loss.

6. The nerve of hearing is often damaged with a resultant profound and irreversible hearing loss. Certain diseases, such as meningitis and mumps, tend to affect the auditory nerve. Some drugs, like streptomycin and quinine, have a predilection for this nerve. This nerve is also secondarily involved as a result of focal infection, lack of vitamins and arteriosclerosis. (This latter is the cause of presbyacusis).

7. Infections or injuries of the temporal lobe of the brain may cause losses of hearing. In some cases the loss is of an aphasic type. In this condition, although hearing may be present, the ability to comprehend the meaning of words is gone. Such a patient acts like an individual listening to a foreign language, who, after a while stops paying attention to what he hears. Conditions involving the inner ear, auditory nerve and temporal lobe of the brain interfere with analysis and perception of sound, and consequently cause "perception" or "nerve deafness" (as opposed to the term "conduction deafness"). Any of the above conditions can be, and often are, modified by psychic factors.

8. There are some conditions which may affect more than one part of the auditory mechanism. Among these are congenital defects, allergy, trauma and otosclerosis. The latter two deserve some additional consideration.

Trauma to the ear may act by (1) direct injury, such as a blow to the skull causing fracture of the temporal bone, (2) concussion, causing a severe shaking up of the contents of the labyrinth (as when a soldier is exposed to the blast of a nearby cannon) and (3) acoustic trauma, meaning injury to the organ of Corti as a result of exposure to long-continued loud sounds. This is particularly important in industry, giving rise to such conditions as "boiler-maker's deafness."

The therapeutic team should know that otosclerosis is extremely important since it attacks the greatest number of victims in the most productive phase of their lives, (1,000,000 in the U.S.). Although the etiology is unknown, it leads to the formation of bone deposits in the oval window hindering, with progressive intensity, the transmission of sound from the inner ear. An operation (fenestration or window operation) which permits sound waves to bypass the oval window was devised by Julius Lempert and has often succeeded in the restoration of hearing.

Heredity is of importance in congenital biologic deafness and, to a lesser extent, in otosclerosis.

EFFECT ON SPEECH

No greater handicap comes as a result of deafness than absence of or impairment of speech. There is, with the rarest exception, no such thing as a "deaf-mute" or a "deaf and dumb" person. If a deaf person cannot talk it is because he has never

(*Continued on page 53*)

DEAFNESS

Problems of Diagnosis and Rehabilitation

PAUL LINDENBERG, M.D.*

Some strides have been made in the rehabilitation of the deaf in recent years, but a great deal has to be done to make the general public and the professions more aware of the plight of the acoustically handicapped, their psychological, social, and economic difficulties. More and better facilities and more and better-trained personnel are still urgently needed.

The medical profession, otologists included, should know more about the comparatively new field of audiology. The otologists generally heretofore have side-stepped the investigation of hearing, having confined their studies to otic pathology and to the field of medical and surgical therapy, leaving the area of rehabilitation almost entirely in the hands of non-medical specialists, who knew more about acoustic physiology and corrective technics. In most instances, unfortunately, rehabilitation of the hard of hearing became the business of hearing-aid salesmen. This situation is changing. Audiology centers are being developed all over the country. Medical and non-medical specialists, well-qualified in the field, work together and train others.

What is the function of an audiology center? A hearing center receives patients for consultation, treatment, and auditory rehabilitation. The sources of referral are physicians, schools, industry, insurance companies, welfare agencies, psychologists and others. The center should be under the medical supervision of an otologist who is especially interested in the field of hearing. The patient is first seen by the otologist who takes a complete medical history and performs a careful otorhinological examination. He orders tests and consultations with other medical specialists as he deems necessary. He treats the patient or advises other medical treatment and makes a tentative plan for rehabilitation.

Lesions causing deafness (using the generic original term deafness for any degree of hearing loss sufficiently severe to cause a handicap) may be situated in one, two or three areas of the hearing mechanism:

(1) If the lesion is situated in the external canal or in the middle ear up to the round and oval windows, in other words, in that part of the hearing mechanism which serves the conduction of sound into the perceptive apparatus, we are dealing with a conduction or obstruction or impedence deafness.

(2) If the lesion is situated in the neuromechanism of the endorgan from the hair cells of the cochlea to the acoustic nerve, which leads into the brain, the perception of sound is impaired and we are dealing with a perceptive or nerve deafness.

(3) If the cortex is unable to sense or understand sound, interpretation is impaired even though the conductive or perceptive apparatus may be intact and in this case we are dealing with cortical or retrolabyrinthine or central deafness.

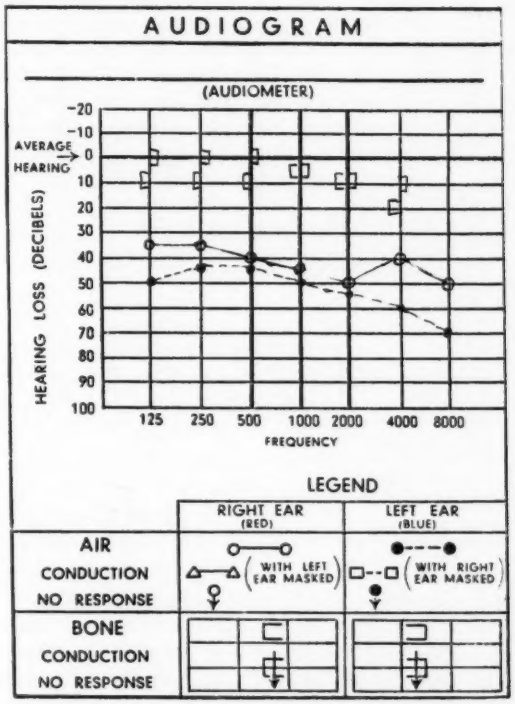


Fig. 1. *An Example of Conductive Deafness*

The examining otologist can see the external canal and the drum membrane. If the drum membrane is perforated, he may be able to inspect the interior of the middle ear. The inner ear and the cortex are not susceptible to inspection. The doctor examines the pharynx, the epipharynx, the oral cavity, the structures of the neck and then the patient is exposed to a battery of hearing tests.

Tests of hearing should be performed in sound-treated rooms with well-calibrated instruments by well-trained personnel. First, a pure tone audiogram for air and bone conduction is done.

Interpretation of the pure tone audiogram (Figure 1) shows an example of conductive deaf-

*From the Department of Otorhinolaryngology, Columbia Presbyterian Medical Center.

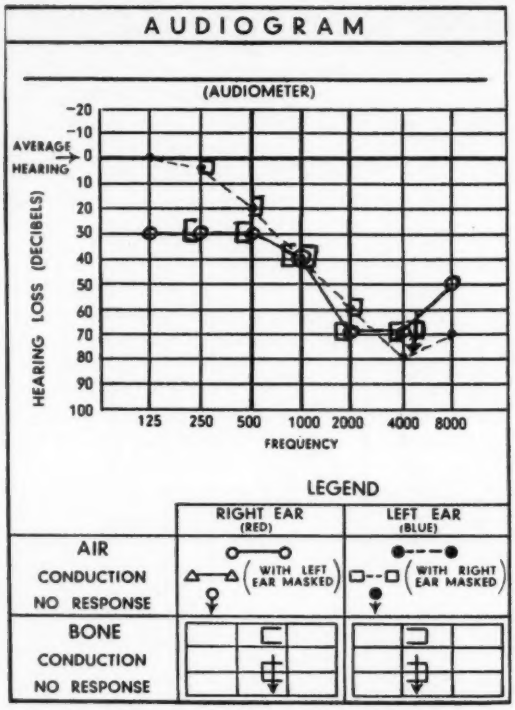


Fig. 2. An Example of Perceptive Deafness

ness. The bone conduction is much better than air conduction. In other words, the inner ear can be reached easier through the bones of the skull than through the external canal and the middle ear; this means, that there must be an obstruction to sound which is situated either in the external canal or in the middle ear. But once the inner ear is reached, sound is well perceived which means that the cochlea, the hearing nerve, and the cortex are in good order.

Figure 2. presents an example for perceptive deafness. Air and bone conduction are equally impaired. No matter how the sound reaches the inner ear, through the bone or through the conductive apparatus, sound perception is the same. The conductive apparatus is in order. Apparently there is no obstruction within the external canals and the middle ear. It is the inner ear wherein the damage lies.

Figure 3. The audiogram is bizarre. Bone and air conduction are not properly correlated. The overall configuration of the audiogram is atypical. A diagnosis is impossible from this audiogram alone. The question is whether this patient is a malingerer, whether he suffers from psychogenic deafness or whether brain damage is present.

Many variations of audiometric configurations are possible. These are three examples for the type of information which may be derived from an audiogram. The otologist interprets the audiogram, correlates it with the history and the physical findings and arrives at a diagnosis. He may decide that the patient's hearing is impaired to such a degree that amplification of sound by means of a hearing aid is needed. He may decide that the patient's hearing is not the problem and that psychological factors have to be taken into consideration to determine the cause for the complaint. In most instances, he will want to have better information about the patient's hearing difficulties and order further tests of hearing to arrive at a proper conclusion.

The tests of a complete audiological workup may include the following: (1) Speech reception

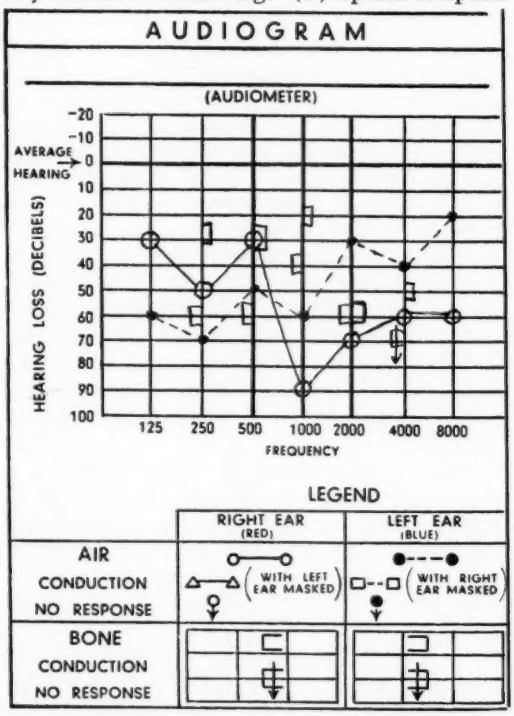


Fig. 3. An Example of an Unreliable Audiogram

tests. (2) Speech discrimination tests. (3) Galvanic skin response audiometry. (4) Recruitment audiometry. (5) Speech to noise ratio. (6) Other tests for confirmation.

It is not within the scope of this paper to discuss these different tests and their interpretation, but two tests will be mentioned because they are important for the plan that is formulated for the patient's rehabilitation.

The speech reception threshhold is nowadays usually determined by exposing the patient to two-syllable words equally weighted called "spondee words." The threshhold of loudness, where a patient can understand fifty per cent of these words, is called the speech reception threshhold. The same words are later presented at the maximum loudness which the patient can tolerate; an important factor for the hearing aid fitting.

The *speech discrimination test.* Phonetically balanced words are used in this test. These represent more difficult material for the ear to analyse; they are mono-syllable words. They have to be heard exactly or will be misunderstood. The percentage of words understood at a loudness level which is comfortable to the patient, and which lies sufficiently above the patient's speech reception threshhold and sufficiently below the patient's loudness tolerance, is determined. These tests will give us the prognosis for the patient's ability to wear a hearing aid. It will give us some idea as to how much training may be needed to acclimate the patient to the use of a hearing aid. It will also give us a clue for the patient's cortical adaptability.

The otologist may decide that consultations with other medical services are needed, such as the internist, the allergist, the psychiatrist, X-ray, laboratory, neurological services and others.

Upon completion of the diagnosis, the otologist will confer with the staff of the Center, and a program will be decided upon. The staff consists of: (1) The audiologist. (2) Lip riding teacher. (3) Speech pathologist and teacher. (4) Psychologist. (5) Social workers. (6) Vocational advisors.

What are the functions of the different members of the clinical staff? The audiologist deals, as the name implies, with clinical, educational and scientific problems of hearing. He is thus responsible for the planning, supervision of construction, maintenance and improvement of equipment. He supervises the technical and educational aspects of the rehabilitation program. He is responsible for the proper execution of hearing tests, fitting of hearing aids and auditory training.

Fitting of a Hearing Aid. There are a great number of hearing aids available. They range in price from $75.00 to $200.00 and more. Those which are accepted by the Council on Physical Medicine of the American Medical Association can be considered adequate aids. Regardless of price, they are about equally durable and equally good in performance. Depending on the voltage of the batteries and construction of the aids, they supply more or less amplification. The stronger ones giving more amplification are usually larger in size than the less powerful aids. Most aids have adjustments that will suppress amplification of high pitches or amplification of low pitches or permit flat amplification of the pitch range. There are many other characteristics of hearing aids well-known to hearing aid fitters. After study of the audiological workup, and the doctor's recommendations, fitters will select three or four aids which are expected to have characteristics suited for the patient's particular needs. Fewer difficulties in the fitting process can be expected from patient's suffering from a conductive type deafness, for instance, from otosclerosis. This type of hearing loss usually responds satisfactorily with any good hearing aid. To select the proper hearing aid for a perceptive deafness, however, is sometimes very difficult. Great skill is needed to find an aid which serves the patient best. This is especially true for the aged person or people with sound tolerance problems whose speech discrimination is impaired.

Sound is brought through the hearing aid into the ear by two routes. (1) *Air conduction* through a plastic ear mold which has to be custom made and which fits snugly within the external ear canal. This mode of transmission of sound produces better fidelity, needs less power from the batteries, causes less distortion and is therefore preferred.

(2) *Bone Conduction.* A bone oscillator is placed behind the ear upon the mastoid bone. Sound is transmitted through the bone directly into the cochlea. This type of transmission is often used when disease of the external canal is present or when the middle ear discharges pus. In rare instances of a severe conductive deafness, where the bone conduction is unusually good, a bone conduction type hearing aid is preferred.

The fitting of a hearing aid is conducted in a sound-proofed room. The threshhold of the ambient noise should be carefully measured and should be in the neighborhood of not more than 30 db. Each hearing aid is tried out under identical conditions so that objective conclusions can be drawn from the tests, and the performance of the individual aids can be compared with each other. Important criteria for selection of a hearing aid are: The speech reception threshhold with the individual aid, the maximum loudness which can be tolerated with aid, the discrimination of speech obtained and its behavior under noisy conditions. The patient's own opinion is invited; does the voice amplified by the aid sound rough, noisy, pleasant, harsh, altered, etc.

Auditory Training. This is conducted by an audiologist, whose interest is in the educational field. He instructs the patient in the proper use of the hearing aid and its general maintenance. The patient learns to recognize malfunction of his instrument, as for instance, defects of the cord, worn out batteries, receivers and other trouble. He learns how to use the hearing aid, when and where. He learns that the hearing aid is an electrical and mechanical instrument that does not produce natural hearing. It amplifies sound up to certain frequencies only. (Usually hearing aids do not amplify above 4,000 cps.) Distortions of sounds are therefore present and the patient has to reconcile himself to it. Furthermore, sounds that were never heard before or that were long forgotten suddenly make their appearance. Loud and new

noises not heard before enter the patient's consciousness and he is apt to listen to these noises, instead of the speech which is the most important factor of all the sounds which suddenly overwhelm him. The brain is to be newly trained and retrained to assimilate these new sensations. The patient learns again to listen. He learns to disregard sounds which confuse understanding of language. He learns to listen in the movies, the theater, the lecture room, in public gatherings, in the machine shop and in a noisy office. These classes are conducted in an informal manner. Throughout the program the patient feels at ease to ask questions and discuss his many problems.

Lip Reading. Most patients do not hear enough with the skills they have learned in auditory training alone. They have to use additional other senses to communicate with the world about them. They learn to watch peoples' faces, especially their lips and expressions. They learn the visual image of the spoken word and learn to differentiate sounds by the positions of the tongue, the teeth, the mouth and the lips, words which the hearing aid fails to reproduce exactly. In many instances, where a hearing aid is not needed because the hearing loss is slight but handicapping, lip reading is recommended. In cases of total deafness lip reading is the main means of communication. Good lip readers may understand up to 50 per cent of the spoken words.

Speech Training. Hearing loss changes voice and articulation; speech patterns characteristic for different types of deafness are readily heard by the experienced instructor. Very often speech defects will uncover a hearing loss. This is especially true for high tone losses in children where the patient and his family may not be even aware of the fact that a hearing loss exists. The speech therapist has to correct defeats of sound production, deviations in loudness and language melody.

The Psychologist's Function in the Clinic. The physician, while arriving at an auditory diagnosis, makes an appraisal of the patient's psychological make-up, and if indicated, refers him for a psychometric evaluation. The psychologist sees all the patients in group sessions where they have an opportunity to ventilate their problems. Individual interviews are also arranged. In weekly staff conferences the progress of patients is discussed and the psychologist guides the therapists in their approach.

Deafness makes varied inroads into the personality. In our society based on intricate systems of communication, the lack of normal and efficient functions of hearing and speech endangers the psychological structure of the individual. Our complex society demands competent hearing and the hard of hearing are penalized. Zeckel[1] ascribes two fundamental psychological aspects to the function of hearing. One, the realistic, the other the symbolic. Discussing the symbolic aspect of hearing, Zeckel employs the Freudian concepts of symbolism indicating that the ear and its function are fundamental in the psychological structure of human beings. This explains the often unrealistic feeling of inadequacy of the hard of hearing and their desire to hide their disability.

Realistically the ear means hearing, communication, orientation in space. Loss of hearing means cutting off from the real world, from the sounds that are around us, from the music of wind, water and trees, the noise of the street, conversation of friends, the theatre, the concert, the Sunday sermon. When the deafened meets strangers, when he applies for a job, he gets flustered; when he gets nervous, his hearing fails him even more. He is afraid people will find him stupid and make fun of him. He avoids company and separates himself more and more from social gatherings. He withdraws from the world of reality. He is alone and depressed. He is unrelated. Nobody loves him.

It is estimated that only 10 per cent of adults, consulting a physician for the cure of their deafness, can be successfully treated by such means as medical or operative procedures.[2] Still, if the patient is advised that the proper use of a hearing aid and lip reading will offer a remedy, he frequently argues violently against the use of such a devise. We should not be impatient and fail to understand the acoustically handicapped who has problems, not only with his fellow man, but also within himself. One hour spent explaining the physiology of hearing and the cause of deafness will relieve a great deal of the patient's anxiety. Knowledge and enlightenment will alleviate the sometimes mystic fear of deafness, and prove to be effective psychological therapy. This is especially true for parents of deafened children whose problems are even more intricate. Not only the children but their parents need help. Parents are made part of the rehabilitation program which helps them to cope with their anxiety and helps them to manage in spite of their frequent feelings of guilt and open and repressed hostility towards their otic cripples.

Summary: This paper indicates methods of diagnosis and problems of rehabilitation of the acoustically handicapped. It points out the activities of the different members of an audiology clinic. It is designed to give therapists, not specifically engaged in the rehabilitation of the deaf, a general picture of the many facets of hearing loss.

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THE PSYCHOLOGICAL IMPLICATIONS OF HEARING IMPAIRMENTS

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Of all the groups of the physically disabled in the United States today, by far the largest is made up of the men, women and children with impaired hearing.[1] Known under the generic title, "the hypacusic", their numbers run into the millions, with some estimates reaching as high as the 20 million mark.[2] This substantial incidence suggests that almost every one of us with normal hearing has at one time or another had some contact with an acoustically disabled person.

Yet despite its extensive occurrence, the real handicaps of impaired hearing still remain something of an enigma to the public mind. The reasons are not hard to find. They stem in large measure from the complex yet invisible nature of acoustic impairments. The casual observer cannot see the physical signs of the disability; and without the stimulus of a visible clue, it becomes extremely difficult for him to imagine what its involvements, complexities and consequences are. The somatic evidence being obscure, the associated psychological handicaps become even more so, but not, of course, to the sufferer.

To him an auditory defect is not a hearing loss alone. It is rather a human loss. Its full impact cannot be demonstrated solely in terms of decibels, nor audiograms nor threshold levels. To the one experiencing such deprivation, it is more like the loss of a life dimension and defies such measures. In the present discussion, the major aim will be to transmit this human aspect of acoustic disability to the reader.

But first, some preliminary orientation is in order concerning the different types of auditory defect. This is necessitated by the fact that these different types give rise to differing psychological problems. Although the impairments themselves are merged together under a generic title, this cannot be done in discussing their psychological implications.

Thus, on reexamining the collective hypacusic group more closely, we find that this vast, "anonymous" body is composed of a widely heterogeneous assortment of hearing-impaired individuals. The layman generally reduces them all to the single denominator, "deaf". However, this is a technical misuse of the term which has the further disadvantage of obscuring the very real and wide range of intra-group differences.

Within the parent body, for example, there are hearing losses ranging in a steady continuum from the mild to the profound, appearing at any time from birth to senescence, and striking suddenly and severely, or increasing slowly and gradually. These acoustic differences, in turn, produce others of yet another character. Such are the differences in psycho-developmental experiences, in educational needs and in social and emotional problems that are either directly or indirectly related to the varying types and amounts of hearing loss present. Over and above these psycho-acoustic differences, there are as well the usual, every day types of individual differences that exist among us all, physically disabled or not. It is not to be wondered that the layman is frequently confused concerning the involvements and implications of impaired hearing.

In order to bring some measure of clarity into this complex picture, numerous attempts have been made to devise an inclusive, orderly scheme of classification of the acoustically impaired population. Educational planning and psychological research alone require such division of the unwieldly parent group into smaller and more homogeneous sub-groups. However this has proved to be a remarkably difficult undertaking mainly because of the debatable borderline cases; and, as yet, neither universal agreement nor the desired, fine classification scheme have been achieved in these areas.

Nonetheless, two broad categories of the hearing impaired population are generally recognized at the present time. They are: (1) the deaf; and (2) the hard of hearing. In addition to these, the writer, for purposes of psychological discussion, recognizes a third category, the deafened, as represented essentially by the war-deafened. Although all of these categories are widely overlapping, the core populations of each are generally distinguishable from one another on the basis of the following differentials: age of onset of impaired hearing and amount of hearing loss sustained; psycho-developmental background; educational needs; and psycho-acoustic problems.

The acoustic differences among these groups are expressed in the following definitions, of which the first two were recommended by the Committee on Nomenclature of the Conference of Executives of American Schools for the Deaf in 1937:

I. *The Deaf*: Those in whom the sense of hearing is non-functional for the ordinary purposes of life. This general group is made up of two distinct classes based entirely on the time of the loss of hearing:

(A) *The congenitally deaf*: Those who were born deaf.

(B) *The adventitiously deaf*: Those who were born with normal hearing but in whom the sense of hearing became non-functional later through illness or accident.

II. *The Hard of Hearing*: Those in whom the sense of hearing, although defective, is functional with or without a hearing aid.

III. *The Deafened*: For purposes of this discussion, the deafened are held to be those in whom the sense of hearing has, with relative suddenness, become non-functional for the ordinary purposes of life during adulthood as a result of accident or illness. The war-deafened are a notable example.

The psychological concomitants and implications of the foregoing types of impaired hearing are presented in the following sections.

THE DEAF

The deaf comprise the smallest section of the total hearing impaired population. According to the various available estimates, it seems doubtful if they number more than about 100,000 throughout the country.[3] In point of size, this is indeed an unimpressive group. However, its numerical insignificance is more than compensated for by the unique nature of its problems. Their unusual quality stems from the fact that of all the hypacusic, the deaf are the only ones in whom the major and crucial portion, if not the whole, of life development must take place without benefit of effective auditory contact with the environment.

This comes about because of the early age of onset of the impairment and the severe amount of hearing loss characterizing this group. The impairment occurs before the age of 5 years in over 90% of the group, and before the age of three in over 70%.[4] The amount of loss involved cannot be pin-pointed precisely; but it is generally held to average about 85 db. or more in the better ear.[5] The auditory impairment of the deaf strikes during the most critical psycho-developmental period of childhood. Its presence continues throughout the life span of the individual for there is no known cure for the condition.

When it exists since birth the child so affected is never able to learn anything substantial, so to speak, through the ear—not even how to talk—and highly specialized instructional techniques must be used in his education. When such hearing loss occurs during the childhood period of speech and language development, any continued normal development of these skills ceases and again the special methods must be employed. The layman commonly uses the terms "deaf-mute" or "deaf and dumb" to designate this state. Within the field, however, the term "deaf" alone is preferred; for the fact that the deaf can be taught to speak despite their lack of hearing ability has been successfully demonstrated for a good many years now. They need no longer be considered mute; and they are certainly not dumb.

However the common misapprehension still prevails that it is this speech handicap alone which constitutes the sum and substance of the handicap of deafness. This is far from the case. The speech involvement is, no doubt, the most apparent; but the other complications are no less severe for being more obscure. They are woven within the developmental pattern of the individual and so do not lend themselves to ready inspection. But they are there nevertheless; and by tracing the pattern as it evolves, they too may be seen and understood.

Accordingly let us focus our attention for a moment upon such a pattern in the person of a child born deaf; that is to say, born into an environment rich in comforts and harmonies but from which all meaningful sound is eliminated because it cannot hear. What then is left?

For the baby, it is a world of stillness. He knows nothing of the warmth of mother-sounds that mean love and comfort, the sound of footsteps or the rustle of garments approaching his crib, the lullabies crooning him to sleep, the silly little "boos" and "gurgles", nothing of the sounds that tell him he is loved and not alone. He is deaf to them all. The sounds of fun are stilled too: the laughter; the clapping hands; the squeaky toys and rattles; the mewing kittens, barking puppies, chirpy birds. All is still and quiet. This is a strange, cold world indeed, this otherwise rich environment, without one meaningful sound to stimulate feeling or give added meaning to what is seen.

As the child grows older, he gazes with questioning eyes upon the silent-motion-picture-like world unfolding about him. The only situations which have some meaning for him are the few with which he is already familiar routine. All the rest are a potential threat, for the "why?" of a dawning curiosity is denied him. He has no words; he knows no words; he hears no words. He is occasionally overwhelmed by uncontrollable fears and impulses to rebellion that surge through him, but to no avail. The walls of silence hold fast. He cannot break through to the world about excepting through an inadequate code of gestures and pantomime.

He cannot indicate what is wrong, for he does not know. Neither, in many cases, do the bewildered adults in his environment; for the condition of deafness in the very young child is often an extremely difficult one to recognize, even for a physician. When the correct diagnosis is eventually made, the pre-diagnostic strains, the ultimate emotional impact upon the parents, and their frequently ensuing agitation and panic serve further to distort many a young deaf child's world and threaten his precarious balance in it. Parental guidance, adjustment and acceptance of the situa-

tion are critical necessities to the life-adjustment of a deaf child.

The other is education. This is the deaf child's salvation, just as language is his emancipation. Such a child has a desperate need to know words that combine to form thoughts and thoughts that stimulate thinking; he needs to know the language that calls forth and expresses emotion; and the speech that effects participation in the give-and-take of social intercourse with the world about. He needs to be able to give expression to his unsatisfied "how?" and "why?" feelings; to make known his wishes and his yearnings; he needs to find a healthy outlet for his anxieties and frustrations. In short, he needs a functional two-way system of fluent intellectual, emotional and social communication with the world about.

When he comes of school age, the construction of such a line of communication is begun. The teaching of language, speech and lip reading is the foundation. Construction proceeds slowly, word by word, phrase by phrase, sentence by sentence. But many, many long years must be spent in arduous and painstaking work before the line becomes sufficiently strong to transmit anything like the substantial amounts of information the deaf child requires for his age. It must be remembered that in numerous instances the very young deaf child has no concept whatsoever of what words are, to say nothing of connected language. This is the case with those children born deaf and with those who become deaf before having experienced the functional use of language symbols.

In all cases, the education of the deaf is an astonishing feat of instruction and of learning. In language, the pupil is specifically taught and he must retain the memory of the correct meaning and the correct usage of every word and of every language principle in his gradually increasing vocabulary. In speech, he is shown and must remember the correct tongue-teeth-lip relationship and placement as well as the correct voice and breath qualities of every sound of every word he learns. In lipreading, he is taught and must then be able to identify words and connected language from a speaker's lips through rapid recognition and synthesis of the visible tongue-teeth-lip relationship of what is being said into the meaningful whole. Truly an amazing feat of human patience and ability! It is not to be wondered that it takes such a very long time before the pupil is ready and able to transmit his own thoughts to the hearing world in an understandable approximation of its own language fluency.

And in the meanwhile, the deaf pupil's emotional and social needs continue apace. They do not remain static while language and speech fluency are being mastered. More and more facets of his life require enlightenment, whether the lines of language communication be ready for effective use or not. Information about the hearing world and its ways; facts, matters of common knowledge and custom, reasons, motives; the "know-how" and the "know-why" of interpersonal and social behavior; the why and how of the emotions; all these and more demand answers. A large measure of such enlightenment falls to the special schools for the deaf. It is they, who being most familiar with such needs must plan how to crowd provision for their satisfaction into the space of a school curriculum.

Yet such is the frustrating slowness of language mastery and such the tremendous scope of material to be taught and learned that it becomes impossible to keep the average deaf pupil in pace with his hearing peers. A lag is bound to exist between what the deaf pupil does know and has experienced, and what he should know and should be experiencing for his age, scholastically, socially, and emotionally.[6]

Thus when a young deaf adult is ready to leave school and face the world, he is still under developed in many ways as compared to the hearing. To the hearing world he may even seem backward, odd or peculiar. He is not, at least not in the usual sense of these terms. It is rather his life situation that is peculiar. As a result of its unique restrictions, he is still uninformed or possibly misinformed about many things; his voice and speech strike an unfamiliar sound to the hearing ear; his experiences in the ways of the hearing world are limited and he shows this in his behavior, in his naivete, in his approach to new situations. In addition, he is very apt to be sensitively aware of his own shortcomings, and even more so of the indifference and misconceptions of the hearing world regarding his problems and his needs. But he is still a developing personality, still finding out, still learning, still maturing. The world about is now his teacher and he needs its help, guidance and understanding acceptance.

As for the popular belief that the deaf personality is characterized by withdrawal, moodiness, suspicion and even paranoia, this belongs to the great body of misconceptions regarding the deaf. The fact is that when the deaf are in the company of those who like and understand them—whether other deaf or hearing—it would be hard to find a more vivacious, animated and garrulous assemblage. Naturally psychopathological traits exist among the deaf, as they do among the hearing; but these are the exceptions and not the rule.

The chief and common problems of the deaf stem from psychodevelopmental rather than from psychopathological sources. The hearing impairment of this group imposes a profound type of

environmental deprivation upon its sufferers from a very early age. Prevalent misconceptions stem mainly from a misunderstanding of the nature of the developmental barriers such deprivation imposes and of the problems it creates. It takes tremendous courage and endurance for one who is deaf to gain a secure foothold in the hearing world. A substantial portion of the difficulties involved will be eliminated when society comes to understand such courage and extends friendship and acceptance to its deaf members.

THE HARD OF HEARING

The hard of hearing comprise the major part of the accoustically impaired population. It is estimated that approximately 1,500,000 school-age children alone are included in their number[7], with the adult sufferers swelling this figure by several millions more. Until not so many years ago, the problems of this vast group were the major concern of only a handful of dedicated pioneers, many of whom were themselves hard of hearing. But more recently, an increasing interest in these problems is being manifested as a result of World War II and its substantial numbers of acoustically impaired veterans. At present, the hard of hearing are benefiting from a greater share of public interest and scientific attention than ever before in their history.

But here again, as with the deaf, the psychological implications of the disability are still apt to elude general understanding. The two groups—the deaf and the hard of hearing—often become hopelessly confused with one another in the public mind. In all likelihood it is because too much emphasis is erroneously placed upon the factor of acoustic impairment which is common to both groups. Actually this common factor forms but a fragile link between them. It is far outweighed by the inter-group differences that exist; differences that are most pronounced both acoustically and psychologically.

In acoustic respects, the amount of hearing loss common to the hard of hearing is considerably less than that characterizing the deaf. According to Dr. Clarence D. O'Connor, Superintendent of the Lexington School for the Deaf, it may be represented by the range of 20 to 60 db. However, Dr. O'Connor emphasizes the fact that quantitative estimates, when used to indicate the characteristic amounts of hearing loss of the various hypacusic groups, are only *general* estimates and are broadly overlapping. As he has stated to the writer: "Many factors *other* than the actual amount of hearing loss play an important part in determining whether a particular child is to be considered deaf or hard of hearing. Of two children with the same amount of hearing loss, for example, the superior mental capacity and the healthy emotional structure of the one may reinforce his ability to *use* his remaining hearing to such an extent that he is both actually and categorically a hard of hearing child in psycho-educational respects; while the more limited mental capacity and/or disturbed emotional state of the other may make him a truly deaf child in these same respects. Such factors play an extremely important role in the acoustic borderline area of 60 to 85 db."

To resume: The hard of hearing differ from the deaf not only in the amount of hearing loss present but also in regard to age of onset of the impairment. In the former group, hearing loss is not the overwhelming childhood affliction it is with the deaf, for it may occur at any age. Thus, as a result of these two factors alone, impaired hearing does not present the psychodevelopmental barrier to the hard of hearing that it does to the deaf. Even when present to a profound degree, as in cases of progressive deafness, this happens after the critical psychodevelopmental years of childhood are well past.

In consequence, the hard of hearing have a normal mental familiarity with the concept of language and its usage in communication whereas in the case of the deaf, such familiarity must be more or less artificially cultivated. In fact many of the hard of hearing have at one time enjoyed completely normal auditory and communicative experiences of an advanced order, and many others nearly normal ones with the help of hearing aids and lipreading. Further, the hard of hearing come by their knowledge of the world in the basically natural way; but the deaf only after long years of painstakingly planned and arduous preparation. And finally, whereas the main problems of the deaf stem from the functional absence of the sense of hearing, the main problems of the hard of hearing stem from the strains of adjustment to its functional imperfections.

On the surface the problems of the hard of hearing may appear relatively inconsequential as compared with those of the deaf. But to paraphrase the old quotation, it is a moot question whether "'tis better to have had and lost than never to have had at all." It takes stamina to be deaf in a hearing world; it takes no less stamina to be hard of hearing. The problems differ, but to the individual sufferer, they are problems nonetheless. Let us briefly consider their nature in the case of the hard of hearing.

If the sufferer is a child, in all probability his hearing loss will start out by being a mild one, with neither he nor his parents even aware of its existence. If it remains this way, all to the good, for there will be no problems created on this score. In fact, such a child—or adult too—is considered rather at the low range of normal hearing than hard of hearing. Usually, however, the amount of

loss increases as the time goes by; and as this happens, difficulties arise.

As a rule, the major problems at this early age level stem from a lack of recognition of the condition. So gradual is the increasing loss that the child himself may be quite unaware of its presence. The signs that something is wrong break through nevertheless. They appear in his behavior. His reactions and responses, especially in acoustic situations, become less sure, less appropriate, much to the annoyance and perplexity of those about. As Gordon Berry describes the ensuing situation: "The father thinks Tom is inattentive; the mother calls it preoccupation; the teacher suspects stupidity, his comrades think he does not care, or that he is queer or self-centered."[8] Many different roles are assigned him: he is the dreamy one; the stupid one; the flighty one; the shy one; the queer one.

If the true cause of the behavioral change is recognized in time and the proper corrective measures taken, such a child can be saved from serious and possibly permanent emotional damage. Corrective measures include medical treatment, lipreading, hearing aid, speech correction, special seating in the classroom, and parent guidance, as required. Above all, the correct understanding and management of the child's problems by those in his environment play a highly important role in helping him to adjust to his disability, to accept it, and then proceed to get on with the business of normal living.

But when the condition remains unrecognized, the child's burden becomes a heavy one indeed. He is subjected to as many forms of management, of disfavor and disciplining and to as many varied attitudes as there are opinions regarding the cause of his undesirable behavior. In self-defense he is finally obliged to devise his own compensatory measures in order to protect his ego against the many unjustified assaults. But these defenses only add to his burdens, for they are unhealthy ones and do not touch the real cause of the trouble. He may, for example, become overly aggressive and demanding; he may withdraw into a lovely world of phantasy; he may develop patterns of deceit; he may become overly compliant and good; he may become just the opposite, extremely negativistic and bad. He may resort to any one or combination of such devices to cover up, win favor, obtain recognition. But regardless of which he employs, underneath them all there is an unhappy, frightened and bewildered child, lost in the psychological involvements of his unrecognized or concealed disability. When eventually the secret is out, it may be difficult to remedy the psychological harm done and the child may bear the scars through life. The earliest possible detection and assessment of hearing loss is a critical necessity in the life of a child. It is essential for appropriate educational planning; it is an imperative safeguard for mental health.

Further, this need maintains not only for the child but for the adult sufferer as well. Here too the earliest possible medical investigation and *acceptance* of the diagnostic findings are of critical importance to ultimate adjustment. This may seem a superfluous observation to stress in behalf of those who by reason of their years are "older and wiser." But such are the tensions and emotional strains accompanying hearing loss that the adult, like the child, is frequently driven in panic to similar unhealthy compensatory temptations. To the uninitiated, this would appear to be an unreasonable over-reaction to a somewhat benign disability. But is this, psychologically speaking, a benign disability? Perhaps the real force of its impact upon the individual will be more clearly understood if we were to pause for a moment to consider what hearing rather than hearing loss implies.

Thus, as I sit here in my office writing the draft of this article, all is peaceful and quiet, and I am gratefully aware that there is no distraction to disturb the train of thought. In the background is the usual undercurrent of familiar sounds; but they offer no disturbance. They are just there as evidence of the stream of life about me. Without even listening, I nevertheless hear the shrill, demanding ring of the telephone in the adjoining office and hope that mine won't soon join in. I hear the light patter of sudden rain outdoors and the soft swoosh of tires on the wet pavement and think how lucky I am that my umbrella is at hand. I hear approaching footsteps in the hall outside and hope they will pass by and not into my erstwhile haven of quiet. I hear the sudden burst of children's laughter from the school next door and find myself smiling in empathy and thinking that this is the happiest sound of all sounds. And as I continue with my writing I have the comfortable feeling that all's right with my immediate environment, that the stream of life is continuing apace, and that I am part of it. My bearing in time, space, and *sound* are intact.

But what if all these small, warm and friendly sounds were suddenly blotted out by silence, if even strained listening could not bring them back? What then of my haven of peace and quiet? It would be a haven no longer. Rather would it resemble a cell of isolation through whose thick walls life's hubbub of activity could not penetrate. Its warmth and comfort would be replaced by a stillness that has been likened to death by many who, because of impaired hearing, have had to endure its chill.

It is this feeling of isolation—of living in a dead world—that is the most commonly shared emotional experience of the hard of hearing. Depres-

sion follows closely in its wake. And as the innumerable restrictions of the hearing loss make themselves felt more and more in the individual's social, vocational and emotional spheres of living, resistance and rebellion join in. The impulse to deny, to cover up, to cast blame, to become bitter and hostile are all commonly observed in the unadjusted hard of hearing.

Further the individual's feeling-tone often becomes heavily laden with fear and anxiety. As Westley M. Hunt described the situation:

> The otologist who examines his patient and writes on his record card, "Progressive deafness," has made only a superficial diagnosis. The record might more accurately read: "Diagnosis: fear."
>
> Fear of failure, fear of ridicule, fear of people; fear of new situations, chance encounters, sudden noises, imagined sounds; fear of being slighted, avoided, made conspicuous—these are but a handful of the fears that haunt the waking, and even the sleeping hours of the sufferer from progressive deafness. Small wonder that, at best, he tends to live in an atmosphere of despondency and suspicion. Small wonder that, at worst, he may not particularly want to live at all.[9]

In certain cases of impaired hearing, the individual's lot is made almost completely unendurable by the added complication of tinnitus aurium or head noises. Such inner noises may range from a condition of mild annoyance to one of incessantly piercing din and clang, day and night. Their muting of the patient's potential ability to hear outside sounds is relatively inconsequential compared to the constant strain of their cacophony. Many patients pray for the blessed relief of utter silence even at the expense of the outside sounds. Other conditions frequently accompanying impaired hearing are dizziness, or vertigo, and discharging ears. Like tinnitus, these act as sources of further strain over and above the tensions induced by hearing loss alone.

Yet despite the exhausting emotional drain of this seemingly benign disability, the hard of hearing person must find within himself the strength and courage to bring life to his "dead" world. He must through his own efforts and energies repair its damaged state. He must accept the diagnostic verdict and then fight his way through its blackness; he must learn to read lips, to use a hearing aid without shame, to battle discouragement, fatigue and resignation. He must be able to accept and even make light of his disability, to ask "What did you say" without self-consciousness or chagrin, he must even be able to acknowledge his "nuisance value" without despondency, remembering that all of us are very often nuisances of one kind or another. He must regain and retain his bearings in the stream of life.

To the credit of the human spirit it can be said that the majority of the hard of hearing have proven their ability to adjust satisfactorily to the complex demands of their disability. The various agencies and societies for the hard of hearing must also be credited for their splendid assistance toward this end. However there still remain a substantial number who stay lost in the morass of depression, isolation, and hopelessness, whose days are plagued by hypersensitivity, suspiciousness and irritability. In not accepting their disability they have accepted defeat instead. It is the pattern of characteristics of this unadjusted group of the hard of hearing that is so often erroneously ascribed to the deaf. The main problems of this group of the hard of hearing are psychological; their major treatment needs, psychiatric.

THE DEAFENED

For purposes of acoustic classification, the deafened (who as here defined constitute an adult group) are frequently included in the category of the hard of hearing. There is ample justification for this for the deafened and the hard of hearing have much in common, far more in common with each other than they have with the deaf. Such mutually-shared areas include both psycho-acoustic background and many related emotional experiences. Further those of the so-called deafened who retain even a small amount of hearing which is put to effective use are indeed hard of hearing and so should be classified with this group in acoustic regards.

However, for purposes of psychological consideration, there are various fine points of difference between the groups which warrant special mention. These stem mainly from the fact that for the deafened, hearing loss strikes with suddenness and severity in the prime of adulthood. Unlike the hard of hearing at large, the deafened are afforded relatively little if any preliminary acoustic warning that their auditory life is about to end and as a result, there is little if any opportunity to develop the necessary "set" for the eventuality. The onset of the disability generally finds the sufferer quite unprepared for his plunge into silence. Its impact is thereby considerably more heightened for the deafened than for the hard of hearing, particularly in the social and vocational life spheres.

The resultant differences in emotional response are, as has been previously mentioned, fine points of dissimilarity—differences in degree rather than in kind. Their nature is discussed in conjunction with the deafened because in this group the sudden shock of hearing loss often produces more acute and consequently more clear cut and observable forms of emotional disturbance. This was especially noted in rehabilitation work with the war-deafened.

To resume then: The question of how a particular individual will respond to the shock of hearing loss depends in great measure upon how well integrated a person he is. The healthy personality, no matter which his hypacusic classification, will handle the associated emotional disturbance through purposeful and adaptive behavior. He will face up to the facts, accept their inevitability, and then proceed to plan and carry out a constructive course of action. In short, he finds release from his tensions through healthy outlets.

In the less well integrated person, hearing loss may serve as an overwhelming threat to an already weak and insecure structure. In such cases, the individual is forced to endure a double emotional burden for not only must he cope with the disturbance generated by the hearing loss alone, but also with the already present anxieties and conflicts which have made him the inadequate person he is. He seeks release from tension too but his ways are the less healthy ones. Very often neurotic mechanisms are called forth to help such persons escape their inner turmoils.

One such mechanism is termed "denial," and through its function the hearing impaired patient may deny that there is anything wrong with him at all, either physically or emotionally. Another is a regressive pattern of reaction in which the individual uses the impairment to play the "helpless invalid" and seeks "mothering" from his environment. Still another is the mechanism of "projection" in which the individual, although realizing that something is wrong, nevertheless refuses to accept the fact that something is wrong with him and instead blames his hearing difficulties upon the environment, i.e. people mumble, or there is too much racket about for him to hear what is said, etcetera. Then there is the hysterical reaction, especially seen in overly-dependent personalities, in which the amount of hearing loss present is accentuated for purposes of gaining sympathy and escaping responsibility. The unsuspectedly high incidence of cases such as these in which the major therapeutic need was psychiatric rather than otologic was brought to light by the work of the various military aural rehabilitation centers of World War II.[10]

In numerous other aural casualties of the War, it was found that psychological factors alone were entirely responsible for the patient's loss of hearing with the auditory apparatus itself completely intact and healthy. Such persons are termed "functionally deaf", and they actually cannot hear. They are not pretending or malingering. They have converted their emotional anxieties and conflicts into an acoustic disability, possibly to avoid hearing that, in the environment, which activates inner turmoil. This neurotic phenomenon is termed "conversion hysteria." For the neurotically insecure soldier, it provides a plausible escape from the sounds of battle and bombardment. There is reason to believe that the civilian too avails himself of this same type of neurotic escape from his particular irritations to a far greater extent than has been heretofore supposed.

The experiences of World War II have shown further that the best approach to the recognition and treatment of all the varied psychological and acoustic factors associated with impaired hearing is through the combined skills of a variety of professional disciples, not the least of which are psychiatry and psychology. Inspired by these experiences, there is developing today a whole new professional specialty based upon this combined team approach to the problems of hearing. Known under the name *audiology*, "it embraces every concept of art and science which can contribute to, or form a part of, the propagation of sound, its transmission to the ear, its fate within the human organism, the psychological process based upon the interpretation of the perceived sound, and the consequent reaction of the person to the mental concept engendered."[11] Through the growth of audiology, the outstanding work of the various military aural rehabilitation centers is presently being continued and expanded in behalf of the civilian hypacusic population.

Before concluding this discussion, there remains yet a word to be said in regard to the oft-asked question as to whether or not there is a unique psychology of the hard of hearing. In the opinion of this writer, there is not. There are, to be sure, numerous common problems and common compensations among the members of the group, many unique experiences and certain similar mood disturbances. But in and of themselves, these do not constitute a unique psychology. It would, for example, be truly unique if a group of individuals all suffering the inherently depressing experience of impaired hearing were not to react with depression and mood disturbances. That they do so react is normally expected. From this point on, the healthy personality also reacts in the expected way by eventually finding his bearings again despite the temporary emotional set-back. Again there is nothing unique about this. The less healthy personality too employs no unique devices. He reacts to hearing loss just as he is most apt to respond to any one of a number of crisis situations. In short, it is the personality structure of the individual himself which ultimately determines the type of reaction to impaired hearing. The methods finally selected are neither inherent in, nor predetermined by, nor unique to the disability.

(*Continued on page* 19)

POSITIVE AND NEGATIVE TECHNIQUES TO EMPLOY AND AVOID WITH THE AUDITORY HANDICAPPED

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The incidence of auditory impairment among patients, regardless of what area of service, is unpredictable; yet every occupational therapist should be fundamentally equipped to meet this handicap both theoretically and in the practical presentation of treatment media. To present a more definite concept of the number in this field the 1930 census lists, according to Best,[1] 57,084 in the United States, or 1 out of every 2400 persons in the general population; whereas in 1951 the American Annals of the Deaf[2] records statistically 21,483 school children under this classification.

The primary consideration of this paper will center on the severely impaired or the deaf, whose hearing is such that its functional value is negative in the communication process. It will be concerned mainly with the congenital or adventitious of early age and will present the deaf in terms of the average, not the exceptional, for although we meet the latter occasionally it is the person in the middle that represents the field.

ESTABLISHING RAPPORT

The axiom that states the initial step for successful therapy is the establishment of favorable rapport, has been preached until it is practically a hackneyed expression to all; yet here again may its importance be reiterated. A harmonious relationship will produce purposive movement towards a recognized goal, but to gain this there must be communication between therapist and patient. This entails a common language which is imperative and speech which is desirable. It behooves the occupational therapist who is assigned a deaf patient to study medical and personal history carefully before attempting an introduction. Just as no two normal personalities produce identical behavior, the same can be specified as to the deaf. Each will give a different response depending on the age of onset, degree of loss, type of education, intelligence, heredity and environment.

Communication may be oral, but don't be alarmed if it proves to be manual. The attainment of speech and lip reading is an arduous undertaking of many years duration. Successful acquisition of either ability is not dependent on just application, but hinges on many personal attributes and drives.

Most deaf persons who sign also use finger spelling; therefore if communication proves to be manual, it will be to the therapist's advantage to learn finger spelling. This is not a difficult task and can be mastered efficiently in a short time with some practice. To find the deaf alphabet, locate a large library edition of the dictionary and look under the word "deaf". Trace the alphabet as shown, enlarge approximately three times for a good working image, then practice (one hand is used, preferably the right) first the letters, then words and finally phrases. It is not necessary to be able to read back, the fact that you "cared enough" to learn is virtually a sesame for establishing rapport. It is natural to assume that writing or speech will be resorted to if the patient so indicates.

Because the attainment of language is so arduous and time consuming, many deaf persons are not prolific readers; therefore in presenting the purpose and therapeutic value of occupational therapy, your explanations should be simple yet thorough to acquaint them with this branch of medicine which will be, in all probability, entirely foreign to their knowledge.

Some of the smaller items that come to mind and can at times assume immense proportions are such items as the following: (1) Never use the interrogation method as a means of introduction. Take no written notes to any questions you might ask. (2) Never discuss orally or laugh in the presence of a third party if the deaf person is a poor lip reader, unless you can interpret simultaneously. (3) Questioning, note taking, and oral conversation without interpretation tends to arouse suspicion.

BASIC TECHNIQUES

Gaining attention: To gain attention touch the person, tap the floor, table, chair or any resounding surface for vibration contact; or flash the light switch off and on several times.

It may interest the reader to know that doorbells and alarm clocks can be purchased adapted for the deaf; the former a flashing light signal installed where conveniently seen and the latter a buzzer vibrator to be placed under the pillow.

Speaking: In speaking make certain the light falls on the speaker's face with as little glare as possible for the audience. Speak slowly yet not haltingly; distinctly as against slurring. Talk in a natural, pleasant voice with the muscles of your face relaxed as opposed to shouting and grimacing. Never obstruct your mouth while conversing ex-

(*Continued on page* 21)

NATIONALLY SPEAKING

From the President

Let us discuss further our national committee business. In the last issue we reviewed briefly the permanent conference committee, the education committee, and the publicity and recruitment committee.

The special studies and research committee which stimulated some fine pilot studies under Margaret Rood, its former chairman, will now itself be piloted by Margaret Gleave, director of the Curative Workshop of Racine, Wisconsin. In assuming the responsibilities of this committee, Miss Gleave is aware of our growing needs. Growth has imposed on occupational therapy a need for greater unity and interpretation. To do this we need to study our individual procedures and arrive at a more critical evaluation of our operating techniques and equipment. Because occupational therapy is essentially informal in appearance and deliberately carries an atmosphere of permissiveness, there is a special need for sound underlying framework of decisive therapeutic value. Studies of its effectiveness are becoming more important. Careful methods of recording and filing results are carried on in many centers while others take for granted the value of their efforts.

The special studies and research committee hopes to establish a long-range plan which will become increasingly effective as time goes on. It hopes to stimulate and direct special study efforts to be carried on in a wide range of occupational therapy departments in many parts of the country. Such participation in the study and research program will be on a volunteer basis. In the belief that many aggressive occupational therapy departments would like to participate but find the demands of patient care too arduous to allow time for special projects, the committee will provide a central structure on which many can work to varying degrees.

Chairman "Maggie" Gleave makes the following statement: "There is a definite need for factual, conclusive material to which we can turn and point out specific contributions that can be made by occupational therapy under medical direction in the treatment of patients in every field of medicine. The collection of such material naturally involves a program of research that should be well organized. Because of our lack of such material it seems wise that this subject be approached from a very basic level.

"All of us are interested in broadening our knowledge as to what our equipment is capable of doing, how our techniques might be improved and the application of both of these for better treatment of the diagnostic groups with which we work. With pilot studies in these areas 'under our belt', we will be in a better position to do more advanced research at a future date.

"Such studies, to be of value, must be well organized and controlled. They must be of the nature that any department of occupational therapy may conduct them with little cost other than the hard work involved in compiling facts and figures. They must be conducted in enough departments to produce comprehensive data of the problems being studied."

The chairman proposes the following:

I. General Purpose of the Committee: To conduct critical and exhaustive investigation and experimentation in the application of occupational therapy as a treatment program for the following purposes.
   - A. To evaluate former assumptions
   - B. To discover new facts and their interpretation
   - C. To revise accepted conclusions and/or theories in the light of newly discovered facts
   - D. To apply the newly discovered facts in a practical manner

II. Direction of the Pursuit
   - A. Research may be broken down into two major parts
     1. The accumulation of data
     2. The interpretation of data
   - B. Approach to the problems may be from these points of view
     1. Determine specific questions in the field for which a study will provide the answers.
     2. Recognize material, equipment and facilities available and proceed with organized studies of the same which may reveal new facts or disclose conclusions to substantiate existing theories

III. Areas of Pursuit. The specific questions to be studied, or studies of existing material, equipment and facilities may be done in the following areas
   - A. Specific pieces of equipment
   - B. Specific techniques
   - C. Diagnostic groups in many or all fields

IV. Suggested general plan of organization of committee
   - A. The Committee should be considered as a planning and control group with initial membership confined to include those persons interested in steering this type of project. As work progresses, membership will of necessity enlarge to cover the various fields in which studies will be done.
   - B. Planning must be done with consideration for the needs of the profession.
   - C. There will be need for guidance from qualified sources on the proper methods of accumulation of data.
   - D. There will be need for supervision of a skilled researcher in final analysis of material to insure adequate and accurate interpretation of material.

V. Suggested general plan of operation
   - A. Questionnaires to be developed to go to all or a selected group in major fields to determine
     a. What most needs to be studied

b. What studies are being done independently
c. Who will be willing to do studies

B. Analysis of questionnaires to determine
a. Priority of choice of studies recommended
b. Studies in progress
c. Persons and/or departments interested in doing studies

C. Develop method of compiling data to insure
a. Comprehensive material
b. Unification of material collected

D. Analysis of data for
a. Periodic evaluation
b. Statistical compilations
c. Accurate interpretations

E. Presentation of Results

Such a comprehensive program will not be concluded for some time. Every thinking therapist is urged to concentrate on the possibilities of this program. Without modesty, submit your thoughts to the new chairman. It is hoped that this committee's work will grow into a highly significant factor in the development of occupational therapy. Plans will be laid on a long-range basis. Simple studies must precede great research projects. We shall try to determine what we want, then select techniques and learn to use them in accumulating data and critically evaluating results. You shall hear more of this special studies and research committee.

Another important committee is the committee on legislation and civil service. It will be chaired by Louise Burton, Mountain View, California. (She will have another name by the time this goes to press.) This committee's work is of utmost importance in cooperating with the various civic, state and federal civil service commissioners in their efforts to establish efficiency and tenure in public programs. Being widely distributed throughout a range of states, developments in these areas are significant. We need current information about and a good working relationship with civil service for greatest efficiency of O.T. service.

Martha Schnebly, of the Cerebral Palsy School-Clinic in Atlanta, has agreed to serve as chairman of the nominating committee. Although this committee's work culminates in the presentation of a slate for the election of officers just before the annual meeting, it has gone through many processes before that time. To make the selection of officers a democratic process, the committee calls upon the states to submit names for nomination. The states are urged to respond. Individuals, when asked to serve, are also urged to respond and in the affirmative, if it is possible to do so.

It has been a pleasure to ask people to serve as chairmen of the standing committees. The response was gratifying. Although all are busy people, they had enthusiasm and a positive approach to the job. I am sure their committee members, whom they appoint directly, will enjoy serving.

The registration committee has not been neglected, but functions under its ex-officio chairman, the education secretary, directly from the national office. Members are selected from near-by areas. Reports are forthcoming from Miss Martha Matthews, its running chairman.

Specal working committees are in operation under the standing committees or the Board, and will be and are responsible to the parent group.

See the committee reports elsewhere in this issue and be impressed with the volume of effective work last year's committees have done. We are looking forward to this year's accomplishments which are now well under way.

Henrietta McNary, O.T.R.
President

EDITORIAL

THE UNMET CHALLENGE[1]

Medically, considerable progress has been made in the treatment of the epileptics. As a result many of them would be looking forward, for the first time, to a normal life as a working member of society, but for the refusal of industry to accept them. No longer need they stay at home wracked by their frustrations, and bewildered by their alienation from man. Is it hard to see that the so-called "epileptic personality" is a by-product of our rejection of them? What is indeed amazing is that so many have maintained their integrity so long and so well.

But despite the significant medical progress employers in large numbers still hesitate to open the doors of opportunity. Many of them recoil at the word "epilepsy" and it will take much education to break down this wall of fear. Some employers however are not afraid of epilepsy, and would hire those skilled epileptics who were capable of working full time, if they were freed of liability in the event of injury. Now we can argue that injury is remote if the epileptic is selectively placed; we can argue furthermore that the condition of many is so well controlled that they may never have another seizure; therefore, we may conclude that employers need have no anxiety regarding possible injury.

In pure logic, the arguments are valid; yet, the evidence is indisputable that employers are not convinced. Basically, they feel that as long as an employee may lose consciousness he may suffer injury. Why, therefore, should the employers invite unnecessary risk, they properly ask?

1. These views are my own and do not in any way represent the views of the Division of Vocational Rehabilitation.
2. It may be of interest to point out that in Massachusetts a bill to incorporate this change has just been filed.

In discussing the problem of injury and workmen's compensation an analogy suggests itself at this point. Not so long ago many employers were unwilling to hire workers who had been previously disabled. As a consequence of this reluctance the employers were granted the protection of the Second Injury Provision which is so widely operative in workmen's compensation laws of many states. Incidentally, experience has shown that the fears of employers were unfounded as the payments of compensation for second injuries have been comparatively infrequent. But the lesson to be learned is not that the employers were wrong; rather it is that they did not alter their hiring policies until they were given the protection they sought; namely, that the state share with them the cost in the event of a second injury.

What is suggested is that we stop arguing with the employers and that we protect them concretely in those cases of injury following seizure. Specifically it is suggested here that we extend the principle of the second injury clause so that each state would assume full responsibility for workmen's compensation for epileptics entering employment.[2] Experience may prove again that employers' fears were exaggerated, and that the epileptics may have no more accidents than other workers. In any case, we should respect the point of view of employers and provide the protection they think they need, especially if this kind of protection is the condition precedent for the acceptance of epileptics into employment.

To the individual state, the cost of assuming such responsibility may be less than the present welfare cost for the support of the unemployed epileptics. But cost aside, is it not high time that we meet the challenge of this long neglected group?

Simon S. Olshansky, M.A.
Division of Vocational Rehabilitation
Boston, Massachusetts.

Psychological Implications . . .

(*Continued from page* 15)

SUMMARY

1. In this discussion, the psychological implications of impaired hearing have been considered in regard to the three following Hypacusic groups: (1) the deaf; (2) the hard of hearing; and (3) the deafened. Various acoustic and psychological distinguishing characteristics of each have been presented.
2. Their main psychological problems are briefly generalized as follows:

(a) In the case of the deaf, such problems are basically psycho-developmental and psycho-educational. They stem from the fact that in this group the sense of hearing is nonfunctional for the ordinary purposes of life either since birth or from early childhood.

(b) In the case of the hard of hearing, such problems stem mainly from the strains of emotional adjustment to the functional imperfections of the sense of hearing.

(c) In the case of the deafened, such problems stem from this same source. In addition, there is the added strain derived from the relative suddenness of the onset of the impairment, its severity and the fact that it strikes during the prime of adulthood.

3. The need for the earliest possible detection, assessment, and psychological acceptance of the condition of impaired hearing at all age levels has been stressed.
4. The writer's opinion has been expressed as to whether or not there is a "unique psychology" of the hard of hearing. The writer believes that there is not; and that the ultimate reactions to the psychological impact of impaired hearing depend upon the particular personality structure of the individual concerned and his customary modes of psychological response to crisis situations. They are neither inherent in nor unique to the disability.
5. The range and varied types of psychological reactions to acoustic disability could not be encompassed in this brief discussion, although some examples have been presented. The range of individual differences is, however, hereby acknowledged.

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10. Davis, op. cit., chapters 12 and 16.
11. Canfield, N., *Audiology: The Science of Hearing*, p. 3, Charles C. Thomas, Springfield, Ill., 1949.

The following sources of further information and pamphlet materials concerning the hypacusic are recommended:

American Hearing Society, 817 Fourteenth Street, N.W., Washington 5, D.C.
Gallaudet College, Kendall Green, Washington 2, D.C.
John Tracy Clinic, 924 West 37th Street, Los Angeles 7, California.
Lexington School for the Deaf, 904 Lexington Avenue, New York 21, N.Y.
New York League for the Hard of Hearing, 480 Lexington Avenue, New York 21, N.Y.
The Volta Bureau, 1537 35th Street, Washington 7, D.C.

TEXAS THIS YEAR

Annual Conference of the American Occupational Therapy Association Shamrock Hotel, Houston, Texas

November 13 - 20, 1953

It's not true what they say about Texas . . . We don't have oil wells pumping in every backyard. All the women are not beautiful. We don't wear diamonds hanging from our ears. Some of us even forego mink coats for the lowly cloth type. There are even Texas citizens without cowboy boots or ten-gallon hats.

Disillusioning, isn't it?

But it is true that in Texas . . . We have the friendliest people in the world. We have an ideal winter vacationand. We have hills, trees, water. We have museums, symphonies, art galleries. We have wonderful places to eat, fabulous stores in which to shop.

It is especially true that in Texas . . . We welcome *you* to the unbelievably lovely Hotel Shamrock for the 36th annual conference of the American Occupational Therapy Association on November 13 to 20 to attend the stimulating program prepared especially for you.

Alamo at San Antonio

This stately monument, the San Jacinto Memorial Shaft, rising 570.4 feet, is a memorial to the heroes who won independence for Texas, April 21, 1836, on the San Jacinto battlefield, 22 miles southeast of Houston, Texas. This monument is the tallest of its kind in the world.

At the hotel itself you will find luxurious dining rooms, a private swimming pool, shops, lounges and all the service to make your stay a happy one.

In Houston, the largest city in Texas, you will find many historic points of interest: the San Jacinto Monument, and the Memorial Museum, to name but two. You can visit the Houston Symphony Orchestra, the Houston Museum of Fine Arts, the Ima Hogg collection of early Americans and many other interesting spots.

You will be welcomed at any of the numerous universities, Rice Institute, the University of Texas School of Dentistry, the Texas Southern University.

And that's not all!

You will be but a scant fifty miles from Galveston, the lovely coast city. Our committee is hard at work planning short winter vacationland trips to various parts of Texas.

You will want to see it all!

Austin, the State capitol, with its wonderful University of Texas, its rolling hills, its captivating lakes, (bring your fishing rod and gun); Dallas, cultural center of Texas and home of the fabulous Neiman-Marcus; Fort Worth, a cow town with a six-shootin' past; San Antonio, the old-world city which brings you a bit of Mexico and a look of France—these will be musts on your agenda.

We are looking forward to seeing you. Whether its all work, vacation, or a combination, we shall try to suit your needs.

Remember the date—*November* 13 - 20, 1953.

Remember the place—*Shamrock Hotel, Houston, Texas.*

Remember the reason—*Annual Conference of the American Occupational Therapy Association.*

Texas Welcomes you!

Techniques . . .

(*Continued from page* 16)

cept to stifle a sneeze. The same negation is applicable to closing your eyes when being spoken to or not facing the speaker. Do not expect optimum performance in lip reading at a distance that exceeds ten feet or from the profile view. Repetition of statement is usually necessary for comprehension.

In the case of the hard of hearing using a hearing aid, it is difficult to apprehend conversation against a background of unrelated sound or mixed conversation.

Teaching: All instructional information should be written in very simple language with the addition of illustrations accompanying the text. Go over all material with your patients, making certain they understand the context. The step-board or unit method has proved to be exceedingly profitable. Demonstrate techniques whenever possible in lieu of relying on oral orders for transfer. Remember repetition, emphasis and patience are inseparables in teaching.

Safety: A great deal of stress should be placed on safety education. Use protective guards at all times and maintain your equipment at a high degree of efficiency. Deaf persons, particularly, should be taught not only to check machinery visually but manually before commencing an operation. To wait for the sound of ill-functioning mechanisms is often too late; therefore a definite hazard in any shop.

THERAPEUTIC MEDIA

Selection: In selecting therapuetic media, any activity is appropriate that is not dependent upon the auditory sense. It is wise to avoid loud or continuous noise, darkness or excessive dampness. The first because discomfort from concussion may result in deterioration of residual hearing; while darkness may cause insecurity in balance due to the loss of two senses (sight and hearing) and dampness can produce infection specifically in the auditory region.

Crafts: Most crafts can be utilized. One exception that comes to mind is the raising of metal shapes on a stake where the ring of the hammer indicates true placement. One way to use this method of raising and get accurate results is to mark your stake in such a manner that upon placing the metal at the designated mark it assures correct position.

Don't rely on a bell or any sound to indicate number, time, heat or pressure; instead use a light (preferably red), large dial or a definite number indicator. This is applicable in cooking, graphic processes and office work.

Bibliographical material: The well illustrated pictorial magazine, together with the "best-sellers" of fiction, are best received and enjoyed.

Interpersonal relations: Interpersonal relationships that are contingent on interviewing, introduction, conversation or general socialization should be selected and guided carefully. This is especially true with mixed (hearing and deaf) recreational groups. Action movies and games, pantomine and cards are to be preferred by the deaf to paper-pencil and colloquial games, drama, lectures and concerts.

It is hoped that the presentation of these few fundamental techniques will aid and engender confidence in the uninitiated therapist, for although the problems of deafness are deep, complex and at times can appear insurmountable, work with the auditory handicapped is both challenging and rewarding, not only to self but to those served.

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1. H. Best, "Deafness and the Deaf in the United States", MacMillan Co., N.Y. '43, pages 73 and 126.
2. American Annals of the Deaf, Vol. 97 No. 1, page 257.

For those readers who seek additional information in the field, the writer offers two excellent sources:

The Volta Bureau, 1537 35th St., N.W., Washington 7,
The American Annals of the Deaf, Gallaudet College, Washington 2, D.C.

FEATURED O.T. DEPARTMENTS

OCCUPATIONAL THERAPY DEPARTMENT OF PHYSICAL MEDICINE AND REHABILITATION

Gallinger Hospital, Washington, D.C.
Naomi Ornstein Loeb, O.T.R.[1] and
Arlean Taylor Mooradian, O.T.R.[2]

The various agencies of the District of Columbia dealing with the physically handicapped have long felt the need for a physical medicine and rehabilitation service. Through the combined efforts of the United States Public Health and the District of Columbia Office of Vocational Rehabilitation, a research project of this type was instituted during the latter part of 1950 at Gallinger Municipal Hospital. The purposes were two-fold: first, to demonstrate how community agencies can successfully cooperate in a program of mutual benefit; and, secondly, that physical medicine is a financially sound investment of every dollar spent.

The department of physical medicine and rehabilitation is a major service of this hospital under the direction of a physiatrist. The staff is composed of one resident physician, five physical therapists, two occupational therapists, one full-time rehabilitation councilor and two attendants. Occupational therapy and physical therapy are closely coordinated so that there is no duplication of treatment and maximum benefit is received by the patient. The occupational therapy section of the department is approximately two years old. Before this department was started there was no occupational therapy for the general hospital. The space available at this time is as yet quite limited, utilizing three small rooms and an outdoor area of approximately 800 square feet.

Patients come to the physical medicine department by referral from all the other various hospital

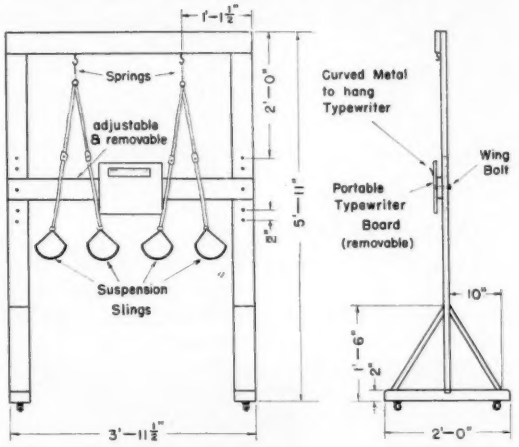


Figure 1

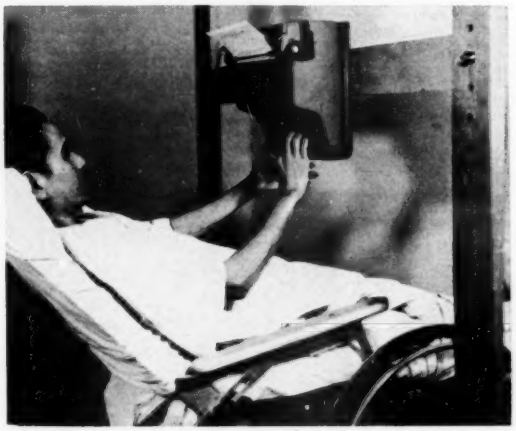


Figure 2

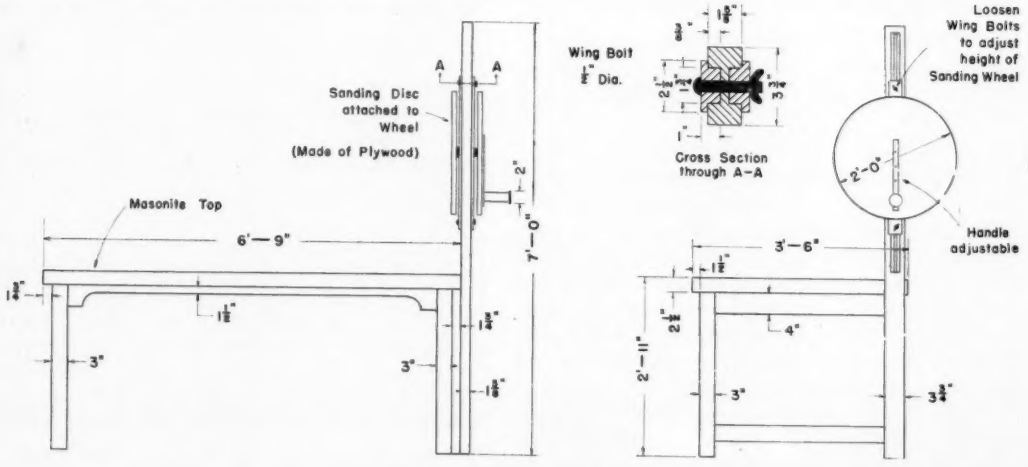


Figure 3

services. In addition, other patients are referred by outside agencies, such as, District of Columbia health department, Gallinger Hospital home care program, Davis Memorial Goodwill Industries, board of public welfare, public assistance division, bureau of child and maternal welfare, District of Columbia jail, District of Columbia office of vocational rehabilitation, and numerous others. A complete evaluation of the patient is then made and the prescription is written by the physiatrist or the resident assistant for occupational therapy and physical therapy treatments. In many cases, where upper and lower extremities are affected, all active exercises of the upper extremity are carried out in occupational therapy and lower extremity activities

Figure 4

in physical therapy. This affords the patient the maximum benefit from the rehabilitation team. The in-patients, after discharge from the hospital, are followed up as out-patients, coming in as often as prescribed. Those clinic patients who are physically unable to come in by public conveyances or automobile are transported to the out-patient department by ambulance or a station wagon manned by attendants. Patients physically able to travel by public conveyances, but financially unable to do so, are aided in this through the social service department of the hospital. The vocational rehabilitation counselor who has been assigned to full-time duty at the hospital by the District of Columbia office of vocational rehabilitation has an excellent opportunity to begin his contribution to the total rehabilitation program at the earliest moment. This is a great advantage to all concerned in that much planning can be done by those who best know the patients' problems and potentialities. When prescribed, vocational rehabilitation provides a service in "obtaining prosthetic devices, such as artificial limbs, and wheel-chairs to preserve or restore the ability of our people to work for pay".[3]

Figure 5

The age level of the patients varies from six to seventy, with an average of thirty-five, while their previous work level is usually that of unskilled labor. No attempt has been made to group patients as to age, sex, or disease. Ninety percent of the prescriptions require kinetic treatment, with self-care and prevocational treatments ensuing. In addition, treatments are given to determine his intellectual and work capacity. This is essentially necessary with hemiplegia patients where there has been considerable brain damage. Occasionally there is a patient requiring metric and tonic treatments. The period of treatment ranges from fifteen minutes to two hours depending upon tolerance and prescription. The diagnoses of the patients are numerous, such as: frozen shoulder, neuritis, Hansen's disease, bursitis, burns, tendon

Figure 6

repairs and skin grafts, cervical contusions, arthritis, nerve injuries, transverse myelitis, fracture, hemiplegia, poliomyelitis, quadriplegia, syringomylelitis, tuberculous meningitis, amyotrophic lateral sclerosis and many others.

The occupational therapy activities include work with a table loom adapted for wrist exercise, large floor loom with extension beater, treadle sewing machine, braid weaving, bicycle saw, both Theracycle and Alexander saw, treadle sander, hand

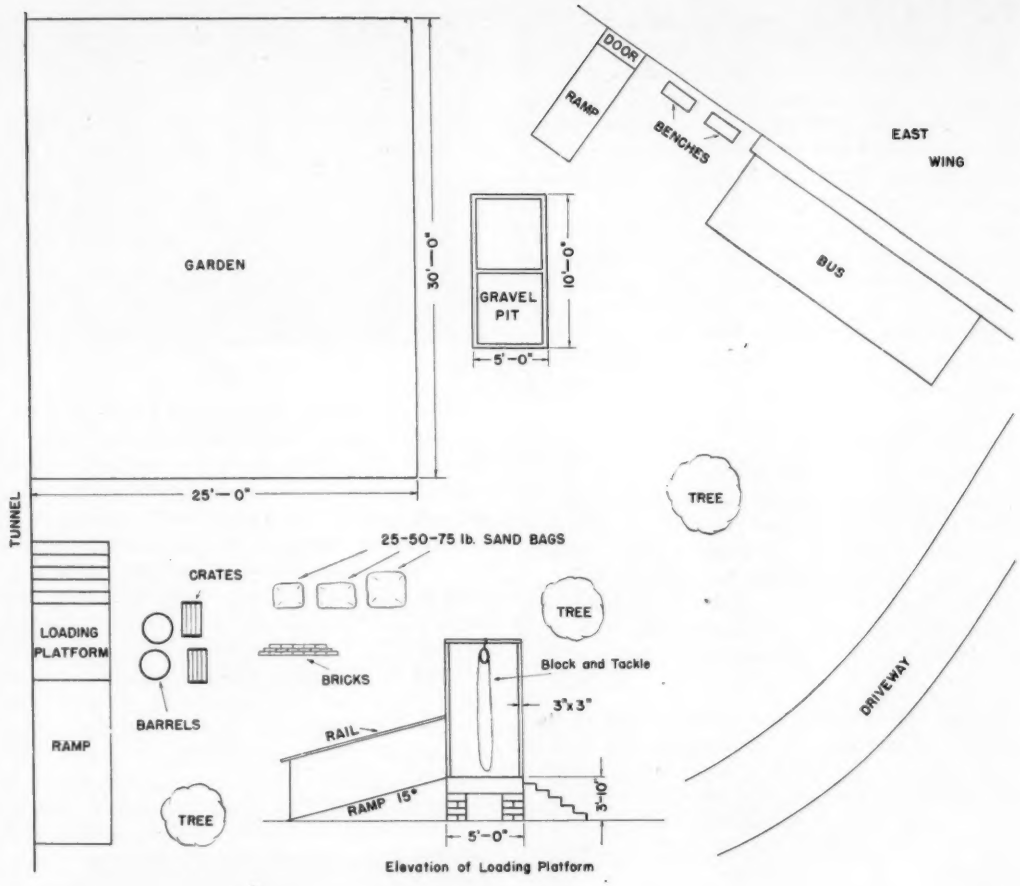


Figure 7

wood-working tools, plastacine and Theraplast, Oppenheimer combination splint, cord knotting, sanding blocks, inclined and horizontal sanding, typing, writing, mechanical drawing, fine arts, daily activities and heavy outside work which will be discussed later in this article.

In order to carry out the above activities, equipment specially designed by the therapists, was built. This includes:

(1) All-purpose frame to be used as a suspension sling or to suspend work such as typing, cord knotting, braiding for bed and wheel chair when the patient is in a reclined position (see figures 1 and 2).

(2) Work tables with varying heights to accomodate all types of wheel chairs, with provision for extended legs, (see figure 3).

(3) Tool cabinets built to be easily accessible to wheel chair patients.

(4) Large work table with attached sanding wheel adjustable in height (see figures 3 and 4).

(5) A gadget board for practicing daily hand activities including light switches, faucets, telephone, latch and locks, etc., (see figure 5).

Daily hand activities are learned by utilization of the various parts of the gadget board. In addition the self-care activities of eating, shaving, writing, washing, combing hair and dressing are taught and practiced. The quadriplegia patients require individually-made gadgets to facilitate self-care and prevocational activities.[4] The patients usually begin their treatments while still on the Stryker frames (see figure 6). Various methods were devised for making gadgets by utilizing materials already present in the shop, such as: dowel stick attached to a razor for shaving; tongue depressor, which prevents rotation of the hand, attached to dowel stick with common nail through end of dowel and used for dialing telephone; eating utensils attached to tongue depressor (all of these fit into slits in the cowhide or webbing metacarpal strap). A coathanger wire bent and taped to an eraser for typing gadgets[4]; lap boards made of plywood; and an exercise mitt made from a hot paid mitt. At present there is under test a new commercially made cock-up splint of aluminum with metal interchangeable gadgets.

Figure 8

An outdoor heavy activities unit is under construction and will be completed within the near future. It will include a gardening area, gravel pit (see figure 7 and 8), saw horse, loading platform with overhead block and tackle and steps. Lifting weighted barrels and sand bags at the platform, carrying buckets and maneuvering a wheelbarrow contribute to outdoor heavy resistance program. A transit company of the city has provided the unit with a bus with which patients will obtain practice in order to overcome transportation problems.

Already the hospital has felt the impact of the physical medicine and rehabilitation service throughout its wards in the striking changes which have taken place in all of its disabled patients, particularly the severely disabled ones. Through demonstrations, conferences and teaching a better understanding of the principles and practice of rehabilitation has been achieved and the way has been opened for a continuing program of development and research. Residents, at the onset of their period on this service, are thoroughly oriented as to theory, aims and treatments available for the various types of patients. Thus as they move on to new services, they are more aware of the Physical Medicine Department and consequently make more and better selected referrals. Student nurses also have a period of orientation and observation and are then encouraged by the nursing instructors to attend treatments with patients so that self-care activities learned in occupational therapy are carried out on the ward and prescribed ward activities are supervised. Being a research project of the United States Public Health Service we have frequently been called upon to outline and give demonstrations of our program to representatives from various countries, which include, Japan, Germany, San Salvedore, Guatamala, France, England, India and Yugoslavia, all of whom are vitally interested in establishing or furthering rehabilitation in their own countries.

The aims of this service are to reduce the period of hospitalization and to develop to the fullest extent the remaining abilities of disabled persons in order that they may assume their most useful and productive positions in society.

REFERENCES

1. Chief of O.T., Dept. of Physical Medicine and Rehabilitation, Gallinger Municipal Hospital, Wash., D.C.
2. Staff therapist.
3. "Vocational Rehabilitation for Civilians", Federal Security Agency, Wash., D.C.
4. "Recent Devices for the Quadriplegic Patient" in this issue.

O.T. FOR THE HOMEBOUND

Heart Association
Washington, D.C.

Nancy Kringel Osserman, O.T.R.
and
Carroll Smith Lewis, O.T.R.

In October, 1949, the Washington Heart Association in the District of Columbia located its first registered occupational therapist. The plan of the executive director and local cardiologists was to fill a need for the adult homebound heart patients of the District of Columbia and nearby Maryland and Virginia.

A superficial survey was made with the assistance of the medical social workers of the six cardiac clinics in the area. It was found that there were close to 500 cardiac adults on the clinic rolls. It was estimated by the clinic physicians that 1/3 to 1/4 of these were partially or completely homebound. With this large figure in mind the Heart Association immediately decided to be very selective in the choice of patients and to limit the number to a small percentage of the caseload of each clinic at the start. This was done with the idea that the O.T. caseload could be increased as soon as the therapist had the help of volunteers and became better acquainted with the geographical layout of the metropolitan area. It was also decided that this program should be limited to adults as the cardiac children were being well cared for by the Maternal and Child Welfare Division of the Health Department.

When this program was established, there were almost no precedents to follow. Following the survey, the next step was to draw up a memorandum describing the program and a medical referral card. Both were brought by the therapist to each clinic for the suggestions of the clinic chief and social worker. This personal meeting with the clinic staffs also afforded the therapist an opportunity to familiarize herself with the mechanism of the clinics and with the personnel as well as to introduce herself. When all changes were made, the forms were printed and copies sent to all the local internists specializing in cardiology as well as to the D. C. Visiting Nurses Association and to all clinic social workers. Besides being in-

HOMEBOUND O.T. SERVICE FOR CARDIAC ADULTS

Mrs. Carroll Lewis, O.T.R., and patient working on craft project.

formative, the memos have proved themselves to be an excellent labor-saving device. A large number of them have been kept on file to be sent on request to social and welfare agencies, clinics, private physicians in related fields, allied associations and to other therapists interested in establishing a cardiac homebound occupational therapy service.

Other record forms, drawn up and filed for active use, were daily and monthly patient reports, discharge notices for the referring physicians, transportation and material expense records.

The program was conceived with the following five main purposes: (1) To teach craft activities which will afford the cardiac patient graded exercise to increase work tolerance. (2) To give a *limited* amount of prevocational training where a more sedentary gainful employment is necessary. (3) To provide interesting activity for mental diversion from the anxieties induced by the illness. (4) To teach energy-saving techniques in housekeeping. (5) To instruct cardiac hemiplegias in self-care and daily activities to increase their independence.

The program was designed as a community service free to all those adult cardiac patients of the District who were referred either by private or clinic physicians and who were acceptable to the program. It was definitely decided that no patient would be treated in the limited office space, but all were to be visited in the home.

After two months of groundwork and organizing, the program was put on an active basis. The therapist in her own car or in a taxi (mileage paid by the week by the Heart Association) with her shopping bag or box of small craft materials such as needlework, leather, gimp, acetate, loopers, copper tooling, etc., an AAA roadmap and a notebook managed to visit 30 patients a week for approximately one hour per treatment. Early mornings and late afternoons have been devoted to paper work and preparation.

In two years following frequent reminders to physicians and social workers, and newspaper and radio stories, the patient load has doubled.

Monthly transportation costs average approximately $35.00 including parking fees with the therapist's own car or $60.00 using public conveyances. Monthly material costs following the initial cost of the department have averaged $20.00. It seems immaterial whether the therapist wears a uniform or civilian clothes on the job.

There is a future plan to have a small interpatient newsletter issued from the department. There has also been an annual Christmas party to bring all the patients together. Mrs. Alben Barkley, wife of the vice-president, attended the 1951 affair.

EVALUATION PROGRAM

The cardiac work evaluation program was organized by the occupational therapy department of the Washington Heart Association in January, 1952. It is actually the outgrowth of a need which developed in the homebound O.T. service. This program has had a well-known, well-established predecessor, Dr. Goldwater's and Dr. Bronstein's work classification unit at Bellevue Hospital in New York City.

Our program differs in that all referrals come from clinic, private, or government physicians. The Bellevue unit accepts its referrals from the employer. The Heart Association project is designed to determine his ultimate referral to a job suitable to his physical disability. This determination is based on an evaluation made by the members of the project unit.

The program was organized with a committee, the work evaluation subcommittee of the rehabilitation committee. The chairman of this subcommittee is a young internist specializing in cardiology. Members of this sub-committee were chosen because of their active interest in the field of job placement as well as their work in the handicapped. This group includes: the director of Goodwill Industries, the civil service commissioner, the medical director of the civil service commission, the director of the U. S. employment service, the medical director of the telephone company, the president and the executive director of the Heart Association, the social service director of a local university hospital, several cardiologists, and the two Heart Association occupational therapists, one acting as the coordinator of the whole project. The

POST-EVALUATION AND PLACEMENT FOLLOW-UP

Patient, teaching remedial reading on part-time basis, observed by Mrs. Nancy Osserman, O.T.R., and employer, Mrs. Marian Kingsbury, director of Remedial Education Center, Washington, D.C.

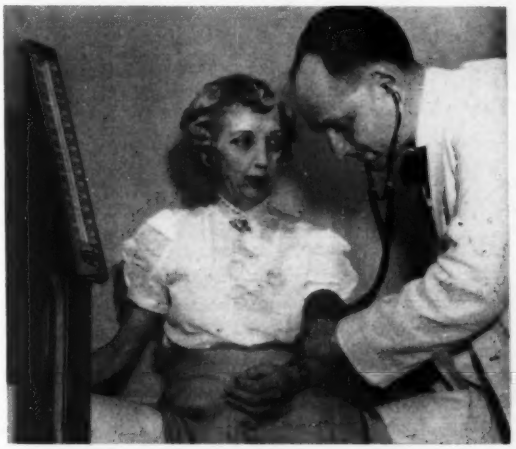
president of the Board of Trade has selected a business man to advise us. The Board of Trade is planing, on our recommendation, to set up an employment clearing house within its large local membership for the placement of all disabilities.

The next step was to organize a unit, at present a travelling one. This unit is composed of the following members who volunteer their time and pool their knowledge: representatives from Goodwill Industries, U. S. employment service, and D. C. vocational rehabilitation, two university vocational counselors alternating attendance at the meetings, a social worker in the case of a clinic patient, a Public Assistance Division worker when the case requires one, the Heart Association therapist, the referring physician, and the O.T. project coordinator.

The mechanism of this program is as follows: the patient is referred to the Heart Association by means of the prescription (referral) card. All patients must have an established organic heart disease. Patients should be under 55 years of age, but exceptions are made. He or she should be able to travel alone. There should be no other major complicating physical or mental disability present. The patient should be unemployed or threatened with unemployment. The patient should be anxious to work. Intelligence should be average or above.

Following the receipt of the complete referral card by the project coordinator, a social interview is taken either by the clinic social worker or in the case of a private patient by the coordinator in an office visit with the patient. A copy of this report accompanies the announcement of each meeting sent to unit members one week in advance.

The meetings are held in the clinic, a hospital conference room, or in the office of the referring physician. The place, date, and hour of the meeting is determined by the referring physician with the project coordinator. The patient is asked to be outside the meeting room thirty minutes after the evaluation is scheduled to begin. This prevents a prolonged waiting period for the patient. The case is introduced and the meeting presided over by the coordinator. The referring physician then presents the pertinent medical information. The unit evaluates each case medically, socially, financially, and vocationally. Some of the simpler psychological problems can be handled by the group, but we prefer not to accept the more complex ones until we can secure the service of a psychiatrist as a full-time member of the unit. Following the review of all records and the evaluation, the patient is interviewed and the plans of the unit discussed with him. The case is then assigned to one of the represented agencies under the direction of the coordinator. A report is given to the referring physician and to the unit members by the project coordinator following completion of action on the case.



PRE-EVALUATION MEDICAL EXAMINATION

Doctor and Teacher-Patient

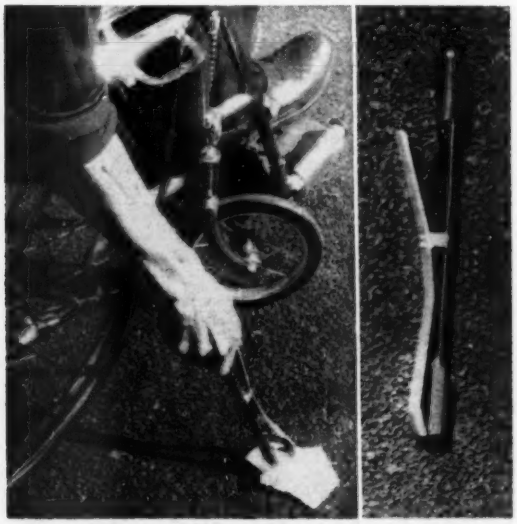
We plan in the near future to have a physician, who will be on a Heart Association fellowship, attend and advise at all unit meetings.

There are a number of other future plans for both divisions of the Washington Heart Association occupational therapy department. It is our intention to set up a student training program as well as a larger, more reliable group of trained volunteers. The ultimate plan for both programs is a large joint service with other local agencies to encompass all disabilities.

APPARATUS AIDS

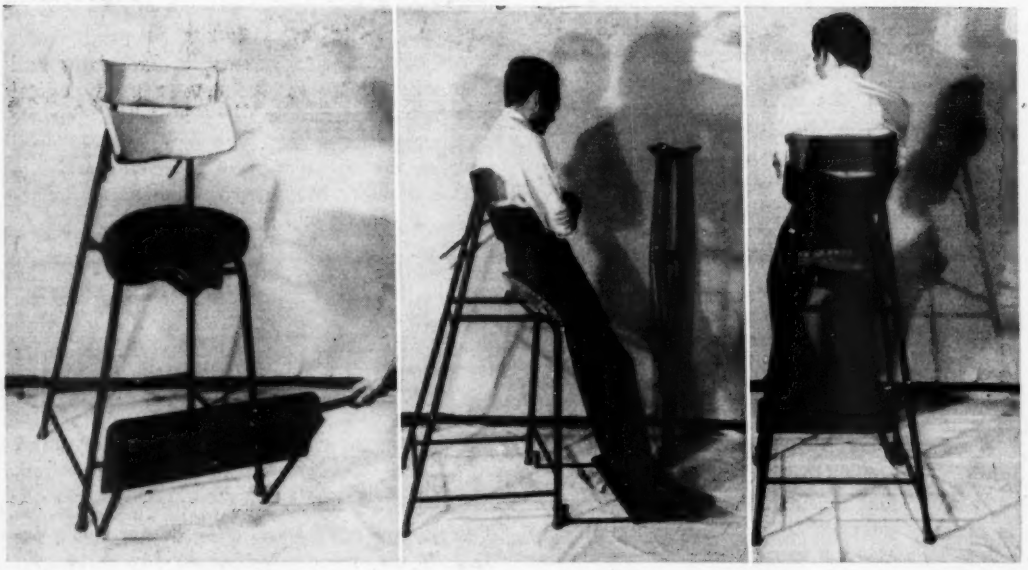
Viola W. Svensson, O.T.R.

Editorial note: This is the first of a series of illustrations of apparatus aids toward independent activities as designed and constructed in the occupational therapy department of the New York State Rehabilitation Hospital, West Haverstraw, N. Y.



PICK-UP BRAKE ATTACHMENT

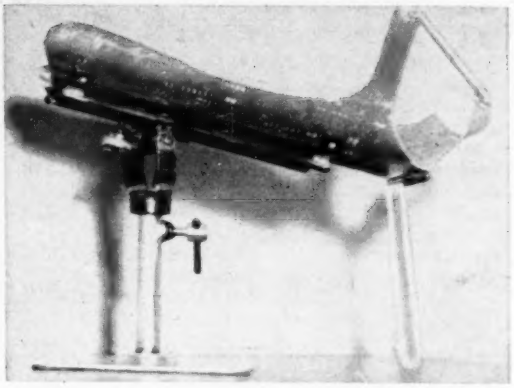
This was suggested by a patient and designed and made in the department. This attachment utilizes the regular detachable brake handle on a metal wheelchair. By adding the prong, it becomes a successful and useful apparatus.



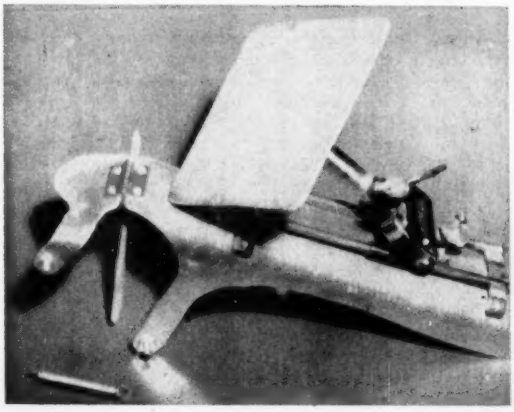
SPECIAL CHAIR FOR A FUSED ARTHRITIC BACK

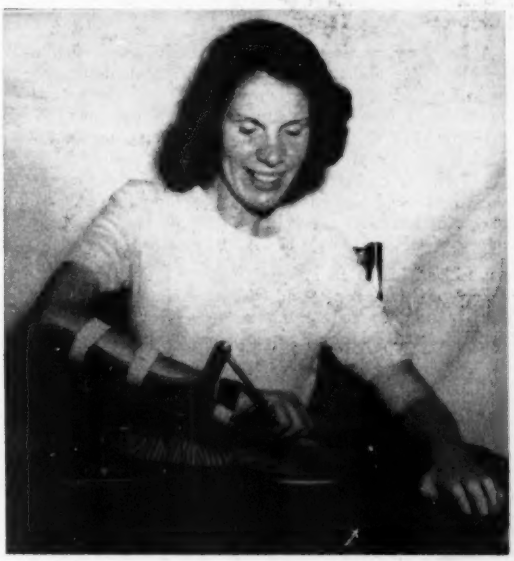
This was built at the request of the Division of Vocational Rehabilitation to construct an apparatus on which a patient who cannot sit may rest or work. With a chair of this sort, the patient is more employable as the apparatus is not clumsy or poor looking, and will allow the patient rest positions without the requirement of a bed.

FEEDING APPARATUS WITH AND WITHOUT TURNTABLE

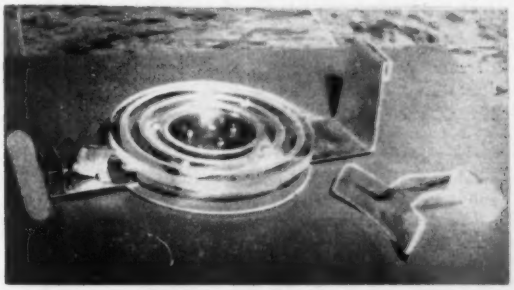


The arm apparatus is built on principles already existing in the profession of aids for physically handicapped, but the design and its individual needs have been made to fit this one patient. This patient is completely flail in the extremity she uses for feeding except for her finger flexors which are very weak but aid in holding the utensil.





The turntable is utilized in training and can be discarded after improvement has been made in the skill of reaching and picking up the food on the plate. However, if this is impossible, the turntable is an excellent gadget, and good-looking for the handicapped patient who will need it at home.



DELEGATES DIVISION

MINNESOTA

Delegate Reporter: A. Genevieve Anderson, O.T.R.

The Minnesota Occupational Therapy Association programs for the year 1951-52 were planned to comply with the membership's expressed preference for occupational therapists speaking on treatment procedures and discussing common problems.

The first of the four general meetings was held at the College of St. Catherine in St. Paul. Sister Jeanne Marie reported on the work being done at Anoka State Hospital and showed slides illustrating the program. She also described the in-service training for personnel at the state hospital. Miss Ann Miller from Sheltering Arms polio hospital discussed her treatment program and the problems peculiar to polio patients.

A February meeting was held at the Minneapolis Curative Workshop and took the form of a panel discussion on cerebral palsy. Mildred Henly, O.T.R., of the Curative Workship, represented occupational therapy, and Miss Hamilton, P.T.R., University of Minnesota, discussed the physical therapy program. Members were shown through the Workshop and the teacher in charge of the pre-school group told us of her work and that of the volunteers from the Junior League.

In March, Mrs. Susan Mahan submitted her resignation as president due to an impending move from the state. It was accepted with regret and with appreciation for the very fine job she did as a comparative newcomer to Minnesota. Mrs. Winifred Johnson completed her term of office.

The Minneapolis Veterans Hospital was the site of an April meeting. No special program was presented because of the length of the agenda for the business meeting, but this was followed by a social gathering in the orthopedic-general medicine clinic.

The outstanding event of the year was the meeting of the Upper Midwest Hospital Association held in St. Paul in May. Hospital personnel from Minnesota, Iowa, North and South Dakota and Manitoba, Canada were in attendance. The theme was "Trends in the Care of the Chronically Ill", and the speaker at the O.T. annual dinner meeting was Dr. William King, consultant to the Division of Gerontology and Chronic Diseases, Indiana State Board of Health. His subject for the evening was "Occupational Therapy with the Aging". At an open meeting during the sessions of the conference, Dr. King presided over a panel discussion of the same subject. Members of the panel were: Linder Keath, superintendent of the Harriet Walker Methodist Home, Minneapolis; Genevieve Cummings, O.T.R., State Division of Social Welfare; and Gerald Kaplan, Hennepin County Welfare Board. The Minnesota O.T. Association had a booth on display which depicted O.T. in the state by means of a map and photographs from various departments.

The same exhibit was set up a week later in the Minneapolis auditorium for the Minnesota Medical Association conference. It is hoped that it may also be used for recruitment purposes.

The Minnesota Occupational Therapy Association has continued to work with the Governor's advisory committee on mental health for improvement in the Minnesota state hospitals. Three therapists were appointed to serve on the subcommittee on physical medicine, and they reported that Dr. Rosen, acting director of the Hastings State Hospital, advised that two or three "pilot" programs be set up at various state hospitals to demonstrate what can be achieved by an organized effort on the part of qualified therapists.

The present membership of M.O.T.A. lists 42 active members and 14 associates. Several new departments have been organized in the past year, and some of the established units have moved into new quarters.

OFFICERS

President	Mrs. Winifred Johnson, O.T.R.
1st Vice-Pres.	Miss Ann Miller, O.T.R.
2nd Vice-Pres.	Miss Jean Roberts, O.T.R.
Secretary	Miss Anna Fandel, O.T.R.
Treasurer	Miss Carol Schad, O.T.R.
Delegate	Miss A. Genevieve Anderson, O.T.R.
Alternate Delegate	Miss Gloria Moen, O.T.R.
Elected members of Exec. Committee	Miss Marion Calph, O.T.R. Miss Pauline Phelps, O.T.R. Mrs. Elsie Anderson, O.T.R.

OREGON

Delegate Reporter: Janet Robbins Ranyard, O.T.R.

The Oregon Occupational Therapy Association cannot claim a long history since its initiation was only a few short years ago. Prior to 1946 there was only one therapist in the state. In 1946 three new departments were established which brought the number of therapists to four, and in 1947 this number had grown to ten. It was then decided to form an association, and by the close of the year this was accomplished. Since that time, the membership has doubled, making a total of twenty and includes all of the therapists in the state and four from nearby Vancouver, Washington. The growth in the membership of the organization is interesting from the standpoint that each additional therapist has usually signified an increase in the number of departments.

Although this is a small group, the publicity committee has managed to accomplish wonders. There is now occupational therapy material in every high school and public library in the state; information regarding the profession has been made available to high school vocational advisors; occupational therapists have become popular speakers at the annual high school career day; and for the past three years an exhibit has been presented at the meetings of the Oregon Tuberculosis Association.

The growing activities of the Association culminated this spring in the Oregon Association being host to the Western International Association of Occupational and Physical Therapists. This conference is a two day session of lectures by eminent physicians and allied professions planned by a local group and attended by approximately one hundred occupational and phyical therapists from British Columbia, Washington, Oregon and California. This year was the fourth annual conference. The theme of the meeting was "Search and Research", and the topics discussed were "The Need for Total Rehabilitation in Poliomyelitis", "The Diagnosis and Treatment of Injuries to the Shoulder Joint", "The Use of Basic Physiologic Reflexes in Physical Medicine Procedures", "Individual Differences in Physicial Constitution" and "Psychoses in the Handicapped".

During the last year nine meetings were held. Recently it was decided to have monthly meetings which are to be held at each department, and speakers or other special programs will be planned by each department at the same time it is host to the group.

OFFICERS

President	Mrs. Jean Vann, O.T.R.
Vice President	Mrs. Evelyn Brill, O.T.R.
Secretary	Miss Mary Minglin, O.T.R.
Treasurer	Miss Clara Brainerd, O.T.R.
Delegate	Mrs. Janet Ranyard, O.T.R.
Alternate Delegate	Miss Grace Black, O.T.R.

COMMITTEE REPORTS

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Hotel Schroeder, Milwaukee, Wisconsin
August, 1952

MEETINGS OF THE BOARD OF MANAGEMENT

The Board meeting was called to order at 9:15 A.M., August 11, 1952, by the president, Mrs. Winifred C. Kahmann.

Roll Call and Proxies

Members Present:

Mrs. Winifred C. Kahmann	Mrs. Veronica Dobranske
Miss Henrietta McNary	Miss Marian Zintek
Miss Helen S. Willard	Miss Eleanor Schreyer
Miss Beatrice Wade	Miss Shirley Bowing
Miss Marjorie Taylor	Miss Maxine Ferrell
Miss Clare S. Spackman	Miss Louise Burton
Miss H. Elizabeth Messick	Mrs. Eleanor S. Owen
Major Ruth A. Robinson	Proxies held for:
Capt. Wilma L. West	Dr. William R. Dunton, Jr.
Sister Jeanne Marie Bonnett	Dr. Walter E. Barton
Miss Patricia Exton	Not represented:
Mrs. Elizabeth Jameson	Dr. Freemont A. Chandler
Miss Marion Davis	Dr. Arthur C. Jones
Dr. Sidney Licht	Dr. Catherine Worthingham
Miss Ella V. Fay	Miss Carlotta Welles
Miss Marguerite Abbott	

Minutes of the Previous Meeting. The minutes of the Mid-Year Board meeting held at the Hotel Drake, Chicago, March 16, 1952, were accepted as distributed by mail.

Report of the Treasurer. Financial statements and budgets for general and educational funds, Association investments, and the Grant Foundation account were distributed to all Board members in advance of the meeting. The budget and financial report were presented subject to adjustments for August expenses which were not available due to incomplete fiscal year.

The treasurer called attention to: (1) $14,500.00 in cash reserve which did not appear on the 1952 budget, thus bringing total reserve fund to $20,715.37; (2) transfer of $6,300.00 in the 1953 budget to educational fund.

Salary raises were requested and approved for A.O.T.A. office staff: educational secretary, assistant to executive director, registration clerk, membership clerk, bookkeeper, A.J.O.T. secretary, clerk-typist in educational office.

The report of the treasurer was accepted with appreciation and the budget voted as present for the 1952-53 fiscal year.

Report of the Executive Director. Prior to the annual meeting, the report was distributed to all Board members. Only those items requiring Board action are herein recorded.

The Board approved of sending a letter of appreciation to the membership and registration clerks and bookkeeper for their long years of loyal service. It was voted that a formal expression of appreciation be sent to Miss Harriet Warren for her services.

There was discussion of the feasibility of continuing the job information service under the present plan or building it into a regular placement service with a fee charge requiring licensing. This would enable devoting more time to it with resulting effectiveness. The present type of referral service is a strong pull to membership and represents one of the most concrete services existing.

The board voted to continue the present plan with an endeavor in the coming year, on the part of the A.O.T.A. office, to make thorough investigation of the number of persons placed, to estimate costs of this service, and to secure further information relative to licensing costs.

The Board voted to leave to discretion of the treasurer and A.O.T.A. office the matter of using a more expensive type of mailing envelope for the Yearbook which would probably ensure better condition upon delivery.

A summary of our status relative to foundations and grants for continuance of our research program was given. Contact continues with the following agencies interested in our proposed projects:

Mac C. Fleischmann Foundation of Nevada; Russell Sage Foundation, N.Y.; Association for the Aid of Crippled Children, N.Y.

The Board was requested to consider appointment of a foundations committee in the nature of a small advisory group to be composed of therapists and other persons. The Board voted that the executive director be empowered to select such a committee to assist her.

The Board voted authorization to dispose of such materials and records in the national office files as are no longer of any value to the Association. (i.e. old orders, requests, working data for reports, etc.) The Board recommended that possibility of microfilming be investigated as means of reducing valuable public relations and historical materials or that they be stored in the schools.

The Board expressed approval of appointing and establishing a special committee for the purpose of compiling a comprehensive history of the Association.

Report accepted with appreciation.

Report of the Speaker of the House of Delegates. Miss Fay reported a total of thirty-one associations seated at the meeting. Oklahoma was not represented. Requests for affiliation with the House were submitted by Arkansas, Florida, and Nebraska. They were voted into membership and the delegates seated.

Proposed constitutional revisions were accepted.

The plan for a brochure designating services of the Association has been abandoned for the present and it was suggested that similar information be put in the Newsletter.

The Federal Civil Defense Administration in Washington was sent a list of delegates through whom civil defense materials could be distributed throughout the membership.

An excellent listing of recruitment media—materials and programs—was announced as available in many of the states.

The House recommended a fact finding committee to secure further information on feasibility of incorporation of state associations.

The House recommended continued support of scholarships in whatever manner the states desired—at national or local level.

The House endorsed the plans of a questionnaire on vital statistics to be prepared in the National Office and sent to delegates. Information to be gathered, compiled and returned to A.O.T.A. office and machinery to be set up for year to year carry-over.

Report accepted with appreciation.

Report of the Educational Secretary. Since the full report had been distributed to all Board members prior to this meeting, Miss Matthews presented a summary.

Student Selection Instruments. In the last (3rd) evaluation run of the present research study, when the clinical training students were the "guinea pigs", the interesting data presented in the three tables was obtained (order of Affiliation, Disability Area and Age Range). The criterion rating (Report of Performance in Clinical Affiliations) is divided into two parts—one consisting of behavior elements and the other a general evaluation of the student on five major components of training. The vlaue of plus .79 indicated high reliability for this type of instrument.

The responses of the clinical training students were analyzed on the five parts. The keys developed on previous runs were used except where new items had been added and required additions to the keys.

Correlation of these scores with those of the criterion rating will be made. The final revision will be determined by the results obtained.

Institute. Miss Carolyn Thompson and Mrs. Fanny Vanderkooi are the able chairmen handling the 1952 and 1953 institutes respectively.

Services to the Schools. A schedule of services to the schools, which the educational office has been rendering, as well as an enumeration of possible future services have been indicated. The financial breakdown of this expense was submitted to the schools in order to determine whether the cost of such special services might continue even though the Kellogg funds were exhausted.

Report accepted with appreciation.

Reports of Chairmen of Standing Committees:

Educational Committee. Miss Willard stated that twenty-one schools were represented at this meeting with guests including Drs. Arestad and Licht and Miss Le Vesconte from the University of Toronto.

Reports were summarized from the sub-committee on graduated study, committee on study of treatment media, committee on shortening the B.S. degree course, and the proposed curriculum for ancillary personnel advanced by the advisory committee on education of the Council on Physical Medicine and Rehabilitation of the A.M.A.

The following recommendations were made: (1) Tentative curricula for reduction of the five year B.S. degree course to four years be submitted for review at mid-year meeting by those schools able to shorten their course.

2. Extended publicizing of "Special Course" (for students already qualified in skills) and encouragement of more schools to inaugurate such courses.

3. Consultation of education of occupational therapists with groups of physicians utilizing occupational therapy (especially the American Psychiatric Association).

Report accepted with thanks.

Registration Committee. The Board voted that the five year ruling on lapse of registration be corrected to read: "That those who permit registration to lapse *for five full years or less* be required to pay all back fees for reinstatement and that those who permit registration to lapse for more than five years must pass the registration exam to qualify for reinstatement."

Miss Matthews presented recommendations of the registration committee relative to reciprocity of registration of two classifications: (1) By writing the registration examination; (2) Without writing the registration examination. The following changes were made in the report on international reciprocity:

I. *B.* 5. *a.* 2. Experience to be secured at various training centers in accordance with A.M.A. essentials (*two months or more at each center*).

II. *D.* That such reciprocity shall be granted on an individual *application* basis only. . . .

II. *D.* 1. The occupational therapist *must* present evidence of successful completion of an *approved course of occupational therapy in his own country.*

II. *D.* 3. The occupational therapist must be a full voting member of his association *or of a classification comparable to that of a registered occupational therapist of the A.O.T.A.* and be recommended by his association.

II. *D.* 4. The occupational therapist must be qualified in all areas of occupational therapy.

II. *D.* 7. All request for reciprocity *must* be submitted. . . .

II. *D.* 8. Upon the granting of reciprocal registration, the occupational therapist may wear the registry emblem and use the letters O.T.R. after his name in conjunction with the letters of his original qualification.

III. Delete

IV. Delete

V. Change to III.

The Board voted that the report on international reciprocity be accepted as amended and that it be published separately and sent to member associations of the World Federation. This is to be accompanied by a cover letter welcoming discussion.

Two doctors have accepted the invitation to participate as medical consultants on the registration committee. Suggestions were requested for coverage in pediatrics and psychiatry. Several names were suggested and the Board left final decision to the discretion of the registration and executive committees.

Report accepted with thanks.

Permanent Conference Committee. Report of the local conference committee was read by Mrs. Murphy, chairman. She reviewed development of the program for the 1953 conference and outlined the plan followed relative to printing a brochure to publicize the symposium session on industry and the letter sent to 38 large Wisconsin industrial firms asking for financial assistance toward the conference as a whole.

Miss Davis presented the report of the permanent conference committee indicating a total of 29 commercial exhibitors occupying 33 booths at the 1952 conference.

The 1953 conference will be held in Houston, Texas, with Mrs. Lucille Lacy as local chairman. The Board voted to shift hotel headquarters from the Rice to the Shamrock and change the date from October 10-17 to November 13-20.

Future conferences have been scheduled as follows: Washington, D.C., 1954; San Francisco, 1955; *possibility* of Minnesota or Atlantic City, N.J., 1956.

Recommendations for further revision of the standard operating procedures of this committee were acted upon as follows:

1. Delete page 4, item 5. g.—letter sent to director of O.T. departments prior to conference.

2. Delete page 15, item 9—advance printing of Institute reservation card.

3. Permanent conference chairman be authorized to draw up S.O.P. for checking of hotel facilities to meet our conference requirements and send to a representative in the area who would report back to the permanent conference chairman.

4. Permanent conference chairman will present to the Board single and alternate choices on where conference shall be for a span of three years relative to city and hotel, maintaining present pattern of geographical shift, with proviso that she make a tentative commitment of hotel when necessary.

The following recommendation (not part of the S.O.P.) was approved by the Board; reading of reports of officers and chairmen of standing committees be eliminated from agenda of House of Delegates. Executive director to be responsible for consolidating these materials in an advance report to delegates and alternates (as prepared for the Board).

Reports of conference chairmen accepted with appreciation of an excellent piece of work.

Special Studies Committee. Miss Rood presented this report indicating the following activities and recommendations:

1. Multiple sclerosis pilot and clinical tests continuing at Cedars of Lebanon Hospital under grant from the National Society for Multiple Sclerosis. Recommended that grant or scholarship, under auspices of A.O.T.A., be

established for full time study of objective testing at one institution.

2. Films produced at Kessler Institute—Bilateral Cineplasty—to be released to O.T. schools this fall; Poliomyelitis Patient in process.

3. G. M. and S. study requests definition and clarification of scope and field of G. M. and S. through House of Delegates.

4. Methodology of educational research chart available through A.O.T.A. at 50c.

5. Selected Studies. Recommended that graduate and under-graduate studies be listed in A.J.O.T. and that selected studies be diversified in publication to allied professional journals.

The Board voted that the manual on splints and bracing be referred back to special studies committee for further investigation of printing and financing.

Report accepted with thanks.

Legislative and Civil Service. Miss Fish gave this report as no committee chairman had been appointed since the recent resignation of Miss Naida Ackley. Eighteen state representatives were present at the committee meeting which made the following recommendations: (1) Re-evaluation of the definition of occupational therapy relative to objectives and scope. Too broad for justification at present.

(2) Need for job classifications in state and other institutions relative to problem of professional personnel shortage.

(3) Advise regarding use of term "rehabilitation therapies" versus "occupational therapy." Unfortunate misinterpretation by state legislatures.

The Minnesota representative requested a statement from the Board to be presented to their membership and to the lgislature relative to licensing in that state. The Board voted that in view of the policy (opposition to licensing) that the entire membership of the Minnesota state association be polled to determine the stand of individual members relative to the feasibility of state licensure. Should such a bill be written in Minnesota, it was requested that a copy be sent to A.O.T.A. for review.

The Board voted further action as follows: (1) That a letter, over signature of the President, be sent to all state associations, with reprint of licensing article by Miss West, re-stating policy.

(2) That a letter be sent to the American Physical Therapy Association (with copy of president's letter) stating our stand on licensing and asking for correction if misunderstanding has prevailed re report that they are urging joint licensing in states.

Report on A.J.O.T. Mrs. Murphy described new advertising promotion through: (1) a series of three letters to potential advertisers; (2) Purchasing power survey sent to practicing therapists for analysis of buying power to be used with new advertisers.

The editor recommended a buyer's guide which would carry a colored supplement and would constitute an issue of the Journal annually. This would mean two issues in one month (preferably April) one of which would be all advertising, thus enabling A.J.O.T. to offer a "package deal" on an 8 time basis to advertisers, including Yearbook. The Board voted that the editor be permitted to try the package deal for a period of one year.

The Board voted that "In Memoriams" be continued. It was agreed that they be craried as they occur and not in any specified issue, with the A.O.T.A. office or officers determining who should be so honored.

The Board voted approval of listing A.J.O.T. in the Milwaukee Telephone Directory.

Report of Chairmen of Special Committees:

World Federation of Occupational Therapists. Prior to the annual meeting, Board members had received copies of Miss Spackman's report, the proposed constitution and standing orders to be voted upon by the membership.

The Board voted to accept membership in The World Federation and to pay the $30.00 fee.

The Board recommended to invite the World Federation to meet with the A.O.T.A. (1954) in Washington, D. C., on separate days, if other arrangements did not work out.

Report accepted with appreciation of time and expense devoted to the World Federation in the interests of occupational therapy.

Committee for Occupational Therapy in Psychiatry. Miss Ridgeway indicated that the plan of regional chairmen was developing and four areas reported large enough groups to undertake projects for the coming year.

180 questionnaires have been returned to date and correlation is underway.

A number of the psychiatric members have indicated interest in a bulletin which would provide exchange of information on special problems, etc.

Report accepted with thanks and the Board voted that the committee be continued for another year.

Constitution Revision Committee. Miss Withers stated that copies of the revisions had been mailed to all A.O.T.A. members 30 days preceding the annual meeting. These revisions were based upon recommendation of the Board at the 1951 conference that changes be made in article II, *members and* article VI, *house of delegates.*

The revisions present a clarification, simplification, and elimination of details already contained in the official organs of the House of Delegates.

The major change relates to Article VI, Section 2: "A state or regional group composed of a majority of registered occupational therapists and meeting the minimum requirements established by the House of Delegates shall be considered eligible for affiliation with the A.O.T.A." This replaces "A state or regional groups composed wholly or in part, of practicing registered therapists"

The Board voted the recommended changes in the constitution.

Recruitment and publicity. No report was given at this time as a detailed outline was included in the executive director's annual report distributed to the Board in advance. See published reports as presented to membership at the annual meeting.

Other Business.

1. The Board voted that advertisers in the Yearbook be given a copy as proof of publication rather than tear sheets only.

The Board voted that registrants who pay late and consequently are not listed in the Yearbook, shall be assessed the $3.00 cost in order to receive a copy.

2. A.O.T.A. membership in related organizations:

The Board voted $25.00 membership in the United States committee of the International Society for the Welfare of Cripples.

The Board voted that membership in the National Health Council be further considered by the executive committee and the treasurer.

The Board voted against membership in the National Conference of Social Work, which was being offered to a selected group of national organizations on an associate or special group status.

3. The Board voted that a committee be appointed to study and revise the definition of O.T. for the Dictionary of Occupational Titles. It was suggested that the New York States Association had been conducting such a study and that investigation of their work be made.

4. The Board suggested that a standard operating procedure for A.O.T.A. committees would be helpful. This S.O.P. on committee organization and function would clarify mechanics for appointment of committees and establish an authentic vehicle for the president and new committee chairmen.

* * * * *

The subsequent meeting of the Board was called to order by the new president, Miss Henrietta McNary on Thursday, August 14, 1952, and the following business was transacted:

The Board voted that the retiring president be invited to sit in on Board meetings, in an advisory capacity, for a period of one year.

Nominating committee. Consideration of chairmanship to be elective. Difficulty has been experienced in securing a yearly chairman at an early enough date. Making this elective would put this office on the ballot with all other officers. Several suggestions were made: (1) That vice-speaker of the House automatically serve as nominating chairman (was done several years ago); (2) that the appointment of a nominating chairman and vice-chairman be made simultaneously with the latter becoming chairman the following year.

The Board voted that the question be referred to the House of Delegates for consideration on a broad basis and that the delegates be instructed to take this matter to their states and inform the speaker of the House of Delegates of their opinions for report at mid-year meeting.

President and Treasurer-Elect. There was discussion of feasibility to ensure better continuity. The Board recommended that a committee of the Board be appointed to study the problem related to the whole slate.

A.M.A. Manual. The Manual of Occupational Therapy, originally published in 1943 in conjunction with the Council on Physical Medicine of the A.M.A., is out of print.

The Board voted that the A.O.T.A. should publish a small manual on O.T. of an integrative nature, discretion to be left to a committee to determine details of format and content.

Use of Insignia for O.T. Aides. There are an increasing number of inquiries relative to a national insignia for aides. Discussion centered around (a) state and federal classifications for aides, (b) re-establishment of a secondary register, (c) recognition of another group.

The Board indicated that the present situation is satisfactory and suggested that a survey of O.T. directors would be helpful relative to feelings and practices and use of the in-service training program for O.T. aides in psychiatric and tuberculosis hospitals. No action taken.

Recognition of 20-Year Registrants. 117 therapists have been registered for a 20 year period without a break in continuity. The Board recommended that appropriate recognition wait until they reach the 25 year mark.

Mid-Year Meeting. An invitation was received to meet in Kansas City, Missouri. The Board voted to accept this invitation for March 14 and 15, 1953, with Indianapolis as a second choice.

House of Delegates Recommendations. The House recommended that sub-professional groups in voluntary hospitals be given token recognition. The Board suggested that Delegates be reminded that these groups are eligible for associate membership in State and National Associations and warned relative to an over-proportion of non-O.T.R.'s.

As a result of constitutional revision, the Western New York Association does not meet requirements for a seat in the House of Delegates (majority of members not O.T.R.'s). It recommended that the Delegates present the situation to her association (H. of D. functions allows one year to work it out) and indicate that change must come within their own group.

Decisions deferred while House of Delegates continues investigation of the possibility of chapters.

Standard Area Division of Country. Regional divisions were suggested as a means of unifying the work of various committees. A plan patterned on the seven Army Areas was discussed. The Board recommended that this be given further study.

Committee Scheduling at Annual Conferences. The permanent conference committee recommended that the executive committee consider proportionate allocation of time for each committee in order to avoid overlapping.

The Board voted that this be passed on to the local chairman.

There being no further business, the meeting was adjourned.

Respectfully submitted,
Marjorie Fish, O.T.R.
Executive Director.

MEETINGS OF THE HOUSE OF DELEGATES

Association	*Delegate*
California, No.	Louise Burton
California, So.	Miriam Thompson
Colorado	Marjorie Ball (Sub. Alt.)
Connecticut	Marion Wright (Alt.)
Dist. of Columbia	Althea Warner
Georgia	Irene Perkins
Hawaii	Charlotte Aspuria
Illinois	Ella V. Fay
Indiana	Marion Kraker
Iowa	Maxine Ferrell
Kansas	Mr. Laurel Nelson (Alt.)
Kentucky	Patricia Moyer (Alt.)
Maryland	Eleanor Owen
Massachusetts	Mrs. Geo. Dobranske
Michigan	Katherine Peabody
Minnesota	Genevieve Anderson
Missouri	Leonelle Gamble
New England, No.	Eileen Dixey
New Jersey	Naida Ackley (Alt.)
New York	Marguerite Abbott
New York, West	Eleanor Schreyer
Ohio	Elizabeth Crumrine (Alt.)
Oregon	Grace Black (Sub. Alt.)
Pennsylvania	Emiko Ishiguro
Pennsylvania, W.	Marjorie Roth
Puerto Rico	Rosa Elisa Jorge (Alt.)
Tennessee	Marion Zintek
Texas	Cornelia Watson
Virginia	Margaret Clarke
Washington	Shirley Bowing
Wisconsin	Norma Smith

Several additional alternates and guests attended the meeting, but did not participate actively in House business.

Report of the Speaker of the House of Delegates. Miss Fay greeted the House and reviewed the report from the midyear Board of Management meeting, which report has been duplicated and distributed to all delegates.

Report of the Secretary of the House of Delegates and the Committee on Credentials. Credentials were approved and delegates of thirty-one associations were seated. Oklahoma was not represented.

The secretary emphasized the need for accuracy in delegates credentials and pointed out that the most recent publication of the Occupational Therapy Yearbook served as the official guide for eligibility of delegates.

Requests for affiliation with the House were submitted by the Arkansas, Florida and Nebraska associations. The committee on credentials reviewed the constitutions and membership lists of all three and found them to be in order.

Arkansas, with the required 12 active members, 4 associates and 1 honorary associate, ratified their constitution on May 24, 1952. According to the rotation plan, Arkansas has been assigned the term from July 1, 1952 to June 30, 1955. It was recommended that the Arkansas association be accepted for membership.

It was voted: That Arkansas be accepted for membership and that the delegate, Virginia Stockwell, be seated.

Florida, with the required 13 active members and 3 associates, ratified their constitution on June 30, 1952. According to the rotation plan, Florida was assigned the term from July 1, 1952 to June 30, 1954. It was recommended that the Florida Association be accepted for membership.

It was voted: That Florida be accepted for membership and that the delegate, Mrs. Pearl Tennyson, be seated.

Nebraska, with the required 12 active members and 5 associates, ratified their constitution on March 8, 1952. According to the rotation plan, Nebraska was assigned the term from July 1, 1952 to June 20, 1955. It was recommended that the Nebraska Association be accepted for membership.

It was voted: That Nebraska be accepted for membership and that the delegate, Miss Sophia Lindahl, be seated upon her arrival.

There are now 35 member associations in the House of Delegates.

Appointment of Committees. The nominating committee was appointed by the speaker. Angeline Howard, Chairman, Veronica Dobranske, Margaret Clarke. The teller's committee was appointed by the speaker: Eleanor Schreyer, Chairman, Marjorie Ball, Charlotte Aspuria.

Civil Defense. It was announced that the list of delegates was sent to the Federal Civil Defense Administration in Washington, D.C., so that material regarding civil defense could be distributed throughout the membership and the profession can participate in this project.

Reports to the House of Delegates.

President, A.O.T.A. Mrs. Winifred Kahmann greeted the delegates. In discussing the problem of licensing, she restated the decision of the Board which was made at Portsmouth, New Hampshire: that they were opposed to licensing as such. However,if the issue of licensing is forced upon an association, all possible assistance will be given by A.O.T.A. to insure the proper support and vehicle.

Mrs. Kahmann reported that representatives of A.O.T.A. and A.P.T.A. met with the American Medical Association and the Council on Physical Medicine to consider the problem of the American Association of Rehabilitation Therapists. A committee is studying this question and efforts are being made to bring these various ancillary groups into focus with the professional services of occupational therapy and physical therapy. Further meetings will be called concerning this problem.

A tentative study concerning a combined course in occupational therapy and physical therapy is being made. Further advice and consideration will be sought before any decision can be made.

Mrs. Kahmann also stated that consideration should be given to the problem of establishing the A.O.T.A. nominating committee on an elective basis to bring continuity and greater countrywide coverage. It was also suggested that consideration should be given to the possibility of providing for "officers elect" who would then carry on with a greater knowledge of such operation of national office, particularly that of the treasurer.

The president emphasized the need of greater willingness of our members to serve on national committees. These members should be selected throughout the country to insure an even geographical distribution of responsibility.

Mrs. Kahmann also projected the idea of establishing local representation in A.O.T.A. by "Chapters" instead of our present state associations.

The report was accepted with a rousing thanks.

Executive Director, A.O.T.A. Miss Marjorie Fish assumed the chairmanship of the legislative and civil service committee because of the resignation of the regular chairman. She urged that each association appoint its own chairman to be a member of the national committee and that such members should be present at the next annual conference.

It was reported that seven A.O.T.A. scholarships had been granted to students in seven schools and that the fund was almost depleted. Miss Fish asked the members to consider means of sustaining this fund.

Miss Fish suggested that more members submit items for the Newsletter, particularly those members in areas other than the East.

It was proposed that individual associations provide permanent exhibits to supplement those provided by A.O.T.A.

Miss Fish distributed a documented statement on "Occupational Therapy 1952" which contained some vital statistics and information about our profession. This was prepared in conjunction with a study sponsored by the National Foundation for Infantile Paralysis and will be available at A.O.T.A. office at a later date. She also stated that a questionnaire will be prepared at A.O.T.A. office and will be sent to the delegates so that they may collect the information in their states, compile and forward it to A.O.T.A. office.

The report was accepted with appreciation.

Permanent Conference Committee. Miss Josephine Davis reported that the 1953 Annual Conference will be held at Houston, Texas, with the Shamrock Hotel as general headquarters. Mrs. Lucille Lacy is the local general chairman; Miss Mary Britton, program chairman; Mrs. Fannie Vanderkooi, Institute chairman.

Miss Davis explained that the Board of Management had recommended the third week in October as conference week. When it was found that Minnesota was unprepared to accept the conference for 1952, Wisconsin kindly agreed to play host. Because of the late notice, hotel space could not be arranged in October, so the month of August was chosen as substitute. Every effort is being made to consolidate the conference time, to keep it at one week or less.

The chairman pointed out that the A.O.T.A. finances the entire conference except for entertainment, favors, parties, teas, corsages, etc. Neighboring states may assist the host through voluntary contributions. There were 29 exhibitors with 33 booths reserved in Milwaukee, bringing a total income of $2,805.00. From this, a $345 plus $12.00 per booth rental is paid the auditorium.

The annual conference in 1954 will be in Washington, D. C., with Virginia and possibly Maryland, assisting.

The report was accepted with appreciation.

Editor, A.J.O.T. Mrs. Lucie Spence Murphy again emphasized the need for the patronization of A.J.O.T. advertisers by the membership.

The editor explained that a forthcoming A.J.O.T. article entitled "Psychodynamics of the Male Patient and the Occupational Therapist" deviates from the policy of referring to any therapist as "he". It was published as written because of the new approach and interesting material. She also referred to another article, "Minimum Standards for an Occupational Therapy Department", prepared by the Research and Study Committee of the Missouri

Occupational Therapy Association. Though it is similar to the A.O.T.A. Manual on this subject, it was included because it is shorter and because the A.J.O.T. reaches many who may never see the Manual.

The report was accepted with appreciation.

Treasurer A.O.T.A. Miss Clare Spackman reported some of the suggestions received in reply to a plea for budgetary ideas and assistance in maintaining the education office are as follows: increase dues, appeal for voluntary sustaining memberships; increase revenue from reprints; increase institute fees; encourage associate memberships. Some checks, anonymous and identified, were received. The appeal for sustaining memberships was effective and the results thus far are gratifying.

The proposed budget, published and distributed, was presented and explained.

The report was accepted with appreciation.

World Federation of Occupational Therapists. The report of the World Federation delegate, Miss Clare Spackman, has been published and distributed to A.O.T.A. delegates. The standing orders and constitution of the World Federation of Occupational Therapists were presented and explained.

The report was accepted with appreciation.

Educational Secretary. Miss Martha Matthews stated that 469 examinees took the registration examination in 1952 and that over 2000 clinical training reports had been received. This is an increase of 30 examinees over 1951. The need for prompt return of clinical training rating forms by O.T. directors was emphasized.

Miss Matthews reported on the development of the student selection instruments and said it would be distributed to the schools this fall.

The report was accepted with apprceiation.

Committee on Special Studies. Miss Margaret Rood, Chairman, reported that a manual on "How to do Re-Search" is now available at A.O.T.A. office. She suggested that those interested in statistical research should take a course on this subject.

She reported that the Multiple Sclerosis Society had made a grant to continue the pilot study on 2000 M.S. patients. Of the original test items, only 2 held up. New tests for coordination and functional ability are being devised.

The study on cerebral palsy has been discontinued because the parents of the patients would not permit their children to be part of a control group (receiving no occupational therapy).

Miss Rood announced the completion of two films on amputee training by the Kessler Institute, New Jersey.

She also announced that her committee is reviewing the journals of allied fields and will report any interesting articles through the Newsletter. She also urged delegates to notify her committee of any special studies which they are carrying on.

The report was accepted with appreciation.

Constitutional Revisions Committee. Miss Elizabeth Withers, Chairman, stated that copies of the revisions had been mailed to all members of A.O.T.A. 30 days or more preceding the annual conference. She then read the proposed revisions, which were acted on one by one.

It was voted: That Article II, Section 1 and 2, be accepted as read.

It was voted: That Article VI, Section 2, become Section 1 and that it be accepted as revised.

It was voted: That Article VI, Section 1, become Section 2 and that it be accepted as revised. (Unanimous vote with Western New York abstaining.)

It was voted: That Article VI, Sections 3, 5, 6 and 7, be accepted as revised.

Old Business

Brochure. Mr. Laurel V. Nelson, chairman, proposed that, because of the great expense involved and the fact that such a brochure would become obsolete after one year, that this project be abandoned. In substitution, he suggested that such information be put in the *Newsletter.*

Considerable discussion followed. Several delegates felt that some basic material about the development and activities of A.O.T.A., in consolidated form, should be available to students and members. No specific action was taken on this suggestion.

It was voted: That the brochure project should be discontinued.

It was voted: That any such information regarding A.O.T.A. be disseminated to the membership through the *Newsletter.*

Recruitment. The following activities were reported by delegates. So. California: Prepared a packet of pertinent literature on O.T. in cooperation with the Army Recruitment Service. Some special Army recruitment material is included.

No. California: Organized recruitment teams which go to high schools for career nights.

Washington: Prepared colored slides of O.T.'s at work in various areas. They have also a recorded speech to go with them so that volunteers may aid in the recruitment program.

Wisconsin: The Milwaukee Journal ran a series of articles on occupational therapy which is now available in booklet form at A.O.T.A. office for 35c.

Tennessee: High school teachers aid in the program, and have "Open House" for 8th grade and high school students.

Iowa: Prepared a series of 15-minute radio programs on occupational therapy which have been tape recorded and are available (see below).

Puerto Rico: Gave talks to students in high schools and have newspaper articles on occupational therapy from time to time.

Michigan: A series of articles on occupational therapy were run in the Sunday newspapers. They also take part in career day programs.

Illinois: Prepared exhibits in orthopedics and tuberculosis which have been shown in schools and tuberculosis association meetings. Members also participate in career day programs. Illinois University occupational therapy students are encouraged to return to their home towns and give talks at high schools and at woman's clubs.

Hawaii: Greatest recruitment aid is annual sale of calendars. This provides $2,000.00 anually for scholarships.

The following recruitment aids are available to occupational therapists throughout the country:

No. California. Three panels, 3 x 6', with standards. Pictures of phases of occupational therapy, physical, emotional and social. Available from: Evelyn Williams, O.T.R., Exhibit Chairman, Mary T. Morrison Center for Rehabilitation, Inc., 1620 Mission Street, San Francisco, California.

Iowa. Transcribed tape recording on occupational therapy, suitable for any location for recruitment. Available from: Department of Occupational Therapy, College of Medicine, University of Iowa, Iowa City, Iowa.

New York. Psychiatric occupational therapy exhibit. Portable exhibit, pictures mounted on panels. Available from: Miss Frieda Behlen, President, New York Occupational Therapy Association, Linden Place, Rosebank, Staten Island, New York, New York.

Colorado. General occupational therapy exhibit, 3 panels, 4' x 8'. Borrower to pay freight from Denver, insure while

in transit and make good any damage incurred. Available from: Miss Marie Dooley, 2385 E. Evans Avenue, Apt. 6, Denver, Colorado.

Washington. Series of slides to be for sale. Set not complete, so cost is undetermined. Information will appear in *Newsletter.* Write to: Lt. Evelyn Eichler, President, Washington Occupational Therapy Asn., Madigan Army Hospital, Tacoma, Washington.

Virginia. Portable exhibit, pictures mounted on panels, complete with explanations. Available from: Miss Margaret Peple, Pine Camp Hospital, Richmond, Virginia.

NEW BUSINESS

Conference vs. Convention. It was announced that the Board of Management at the mid-year meeting in March, 1952, had approved the term "conference" instead of "convention" and it is to be used from now on.

Incorporation. The Speaker announced that the consensus on this matter is that if it is not too costly, a state organization may incorporate. The A.O.T.A. was incorporated in 1917, when it started, and Massachusetts was incorporated. It does not seem essential, since E.T.'s and M.A.T.'s do not wish to be known as O.T.'s. If chapters were established in the place of state associations (see below) they would automatically become an integral part of the incorporated A.O.T.A., and individual incorporation would be superfluous.

Formation of Chapters. This subject was presented and discussed. The advantages seemed to be that it would give better representation throughout the states, better contact with the states and a more authoritative voice for the state with small membership.

It was voted: That a committee be appointed to study the problem of Chapter formation and present the facts to the delegates. The committee was to start work immediately and present a preliminary report by the midyear meeting of the Board.

Scholarships. The following reports were given by delegates regarding scholarship activities in their associations:

Michigan. Provides one scholarship annually for each of three occupational therapy schools in Michigan. Funds raised through sales of various kinds. Recipients of scholarships urged to contribute to the fund when they can.

So. California. Worked with Elks, who provide scholarships for both graduate and undergraduate study, as well as for practicing occupational therapists who wish to take additional courses. They also suggest contacting banks which have nonspecified trust funds. They also receive help from college graduate groups in varying amounts. Suggest using hospital memorial funds.

No. California. Stated that they received excellent help from the American Legion.

Colorado. Proceeds from sale of "At Your Fingertips" is used for scholarships.

Texas. They usually have 5 scholarships available to occupational therapists annually. Two are from alumni of Texas occupational therapy schools.

Illinois. During 1945-48, the Illinois Federation of Women's Clubs raised $35,000 ($25,000 was used to build a greenhouse at Vaughan General Hospital, with $10,000 for upkeep.) $10,000 was donated also for scholarships for occupational therapy students. On two subsequent years, they also provided $2,500 each year for University of Illinois students. The Federation also has a chairman of occupational therapy in each district and in each local club. The Florists Association might be interested in scholarships as they give to nurses.

Arkansas. The Masons and Lions were helping in this project.

Hawii. Donate two $1,000 annual scholarships. ($300 grant and $700 to be repaid after graduation without interest.)

New Jersey. Suggested the idea of voluntary increase in dues of not more than $2, $1.00 should be used for scholarships. Thus, there would also be a fund which could be budgeted and counted on especially in small associations.

Washington. Requested more publicity about available scholarships as many would take advantage of them if they knew they were available and knew of their existence.

A "pennies from Heaven" collection was taken up in the House which netted $9.26. This was presented to the A.O.T.A. Treasurer.

Vital Statistics. Six delegates reported that they have already secured the information as suggested in the letter from the Speaker. *It was voted*: That the A.O.T.A. office staff prepare a questionnaire on vital statistics and send copies to the delegates of the local association. The information would be gathered and compiled and returned to A.O.T.A. office.

Licensing. The speaker reported that this was discussed by the Board. As previously decided at New Hampshire the Board emphasized their position. Some of the pitfalls are: control of the bill, high costs involved, lack of backing in legal matters. No definite action was taken. Delegates were referred to the article by Miss West in April, 1951, A.J.O.T.

Reports from A.O.T.A. Officers and Committee Chairmen. The Board decided to send all reports of the Board of Management and special committee chairmen to each delegate preceding the annual conference. This will allow delegates to be familiar with this material and will eliminate the need of lengthy reports before the House. Only items which need special emphasis or recent items will be presented at the time of the meeting.

Legislative and Civil Service Committee. The former chairman emphasized the need of a local chairman to: keep abreast of all civil service examinations and requirements, job analyses and to know what pertinent bills are coming up in the legislature. Be sure to keep the national chairman advised of special items. Seventeen associations already have such a chairman.

Special Reports and Other Material for Delegates.

It was voted: That one copy of all House reports or other material be sent to each delegate and alternate delegate except in the case of the House officers when two copies should be sent. (One for the House file and one for the delegates' asociaiton file.)

In Memoriams. The Board reported that "In Memoriams" are presented in A.J.O.T. to honor a member of our profession for outstanding service and as a special expression to the family of the member designated. Such articles should be prepared with specific facts and sent to A.O.T.A. office. It will be then sent to A.J.O.T. for publication.

Rehabilitation Therapists. Washington once again brought this matter up for discussion and presented many notes quoting from the A.A.R.T. Bulletin. A long discussion ensued with many suggestions. It was suggested that non-professional workers be given consideration and that they be given special training as aides. That, if possible, they be given some sort of certificate of recognition.

Texas reported that there is a training program for nursing and occupational therapy students as assistants, in Junior Colleges and in hospitals. Mrs. Coombs can give further information. New Jersey reported that their state has solved the problem by designating this personnel as "Institutional aides" in nursing, occupational therapy, etc. Washington moved that, if any substantial scholarships were set up, that part of it might assist M.A.T.'s in V.A. to take course so that they could become occupational therapists. Voted, but not carried.

The House was assured by the Speaker that these matters were under consideration, as previously reported to the House by Mrs. Kahmann.

Clarification of Agenda. It was voted: That action taken at the House of Delegates meeting in 1948 be re-emphasized. Specifically, that a letter of explanation on articles appearing on the agenda be sent to each delegate to be sure that all items are clear.

Election of Officers and Delegate Board Members. The following officers were elected:

Speaker of the
House of Delegates .... Marguerite Abbott, New York

Vice-Speaker of the
House of Delegates .... Emiko Ishiguro, Pennsylvania

Secretary of the
House of Delegates .... Miriam Thompson, S. Calif.

Delegate Members of the
Board of Management .. Marian Zintek, Tennessee
Shirley Bowing, Washington

The Speaker relinquished the chair to her successor. The new officers were greeted.

Final Meeting of the House of Delegates. A final meeting of the House of Delegates was held following the last meeting of the Board of Management. The newly-elected Speaker of the House, Marguerite Abbott, reported the following recommendations and Board action.

Nominating Chairman of A.O.T.A. The Board of Management referred to the House of Delegates the suggestion that the nominating chairman be elected each year. The speaker was instructed to get an opinion on this from the delegates who should inform the speaker of the opinion of their membership by the mid-year meeting.

The meeting adjourned.

Respectfully submitted,
Marguerite Abbott, O.T.R.,
Speaker, House of Delegates.

SPECIAL STUDIES COMMITTEE

Members Present: M. Abbott, V. Dobranske, M. L. Franciscus, A. Howard, M. Rood, F. Behlen, H. McNary, F. Stattel.

Not Present: Sister Jeanne Marie, Sister Mary Arthur, Ruth Robinson, Clare Spackman, Mary Brach, M. Mathews.

1. Pilot test carried out by Elizabeth Warren, graduate student, University of Southern California, on tests selected by Mildred Bond in her graduate project on objective tests of manual dexterity. Eight patients active, 10 patients controlled. Multiple Sclerosis at Cedars of Lebanon Hospital, Los Angeles, Calif.

Results: Tapping test and peg test—improvement. Correlated with clinical findings but Gate test did not. Gate test 17.7 increase control group, 5.0 increase active group.

New project for 1952. Continuation of above project with 300 patients to be carried out under the direction of Arthur Bockstaler, O.T.R., under John Aldes, M.D. Director of the Department of Physical Medicine and Rehabilitation. This department under a grant from the National Society for M.S. is engaged in a total study of the results of treatment for the multiple sclerosis patient. Of 2000 applications, 300 patients have already been selected for the total testing program and of this group 100 have been on this occupational therapy study of coordination tests.

Results: Report on the 100 is not conclusive. Mr. Bockstaler recommends a change in tests with a suggestion that a maze test is a better criterion of ability for this type of patient. He requests further suggestions for the continuation of the study. The following were made by our committee:

a. Tests should be functional for more gross movements, rather than paper and pencil tests.

b. Continue tap and peg test as a correlation with the functional test.

c. A grant or scholarship on a competitive basis should be established for a full time study of objective testing at one institution under auspices of A.O.T.A. This should be limited to the field of orthopedic and neuromuscular disabilities.

The individual selected to guide this study be a psychology major or a person familiar with testing procedures, such a person should investigate existing tests.

2. Film, Bilateral Cineplasty Film, reviewed last year will be ready for release to schools only, this fall. This was produced at Kessler Institute under directions of F. Stattel. Contact her for bookings Rehabilitation of the Severely Handicapped—Poliomyelitis patient, now in process, Kessler Institute, F. Stattel.

3. G.M. and S. Study—Angeline Howard. A summary of the work carried out under the clinical training council of Wisconsin. The sub-committee on clinical training has requested a definition and clarification of the scope and field of G.M. and S. The special studies wishes to recommend through the House of Delegates that similar studies be initiated. Contact Miss Howard.

4. Methods of Research. Excerpts of Good, Barr, Scates. Methodology of educational research has been done on chart form, available for purchase. The committee wishes to suggest that it be made available through the A.O.T.A. office for sale to the membership.

Statistics: The committee found it impossible to do brief excerpting of statistical methods and suggests that anyone interested should take a course under definite guidance. The College Outline Series on Educational Measurements and Statistics, is suggested as a reference.

5. Selected Studies. Biannually selected graduate and under-graduate studies should be listed in A.J.O.T. These studies should be sent or brought to Miss Mathews or the special studies committee at the mid-year and annual meetings. Each committee member is to report on any interesting studies in her geographical area. Recommendations made by this committee at mid-year meetings for reports of special studies at the convention are being fulfilled at this convention.

Publication of Studies. The American Heart Association wishes to publish "A Guide in Activities of Teen Aged Rheumatic Fever Out Patients," Mary Ellen Dodds.

Studies selected this year will be diversified in publication to allied professional journals.

6. Review of literature by committee. Medical and allied professional journals are to be read and selected pertinent articles listed and sent to A.J.O.T. regularly for publication at the discretion of the editor.

Readers' Guide. M. Abbott suggested that the committee consider as a future project the compilation of a readers' guide in various areas of disability in relation to occupational therapy.

7. Splint Manual—Material collected but printing by Wm. C. Brown would require guarantee of number, which cannot be done.

Respectfully submitted,
Margaret S. Rood, O.T.R.
Chairman.
Florence M. Stattel, O.T.R.
Secretary.

REPORT OF THE TREASURER

General Fund

	Actual Inc. & Exp. Year ending Aug. 31, 1951	Actual Inc. & Exp. Year ending Aug. 31, 1952	Approved Budget Year ending Aug. 31, 1952	Proposed Budget Year ending Aug. 31, 1953
INCOME:				
Endowment	$	$ 16.43	$	$
Reserve for Scholarship Donations	474.86	385.00	100.00	
Registration Fees	18,855.00	20,423.60	19,500.00	20,500.00
Membership Dues	14,608.00	20,657.00	20,000.00	21,000.00
A.J.O.T., Subscriptions	12,259.46	12,921.65	12,500.00	12,500.00
Advertising	7,662.60	8,559.83	8,000.00	8,000.00
Yearbook, Sales	270.88	149.88	250.00	200.00
Advertising	1,720.24	1,782.65	1,700.00	1,800.00
Sales (Reprints, Insignia, O.T. Pins)	1,988.25	3,115.77	2,000.00	3,000.00
Volunteer Course	154.00	153.00	150.00	150.00
Convention, Previous Year	2,377.45	2,110.62	2,100.00	
Current Year	1,952.50	8,238.70	3,500.00	2,000.00
Interest, Bank and Bond	525.82	541.33	500.00	550.00
Trans. from Reserve for Scholarship		877.00	877.00	
	$62,849.06	$79,932.46	$71,177.00	$69,700.00
EXPENSES:				
Cost of Sales (Reprints, Insignia, O.T. Pins)	$ 1,556.89	$ 2,464.02	$ 1,700.00	$ 2,500.00
Furniture and Fixtures	262.62	154.15	100.00	150.00
Depreciation	403.93	418.27	425.00	440.00
Payroll	17,358.56	17,657.87	18,500.00	18,500.00
Audit and Legal Expense	245.00	145.00	150.00	150.00
Bonding		33.75	35.00	
Books and Subscriptions	119.50	111.47	150.00	150.00
Office Repairs	337.11	134.77	200.00	200.00
Office Supplies	1,409.46	1,543.90	1,300.00	1,400.00
Postage and Expressage	1,585.09	2,096.92	2,000.00	2,200.00
Printing, Yearbook	4,829.91	4,833.93	4,400.00	4,800.00
Other	1,056.16	1,166.43	1,100.00	1,000.00
Rent and Light	2,100.00	2,100.00	2,100.00	2,100.00
Telephone and Telegraph	518.01	521.95	500.00	500.00
Travel	950.78	727.06	1,400.00	1,400.00
Payroll Taxes	997.50	1,112.00	1,500.00	1,500.00
Convention, Previous Year	2,874.00	2,312.16	2,350.00	200.00
Current Year	275.55	4,920.85	2,500.00	150.00
Exhibit	344.63	189.68	200.00	500.00
Cooperation with Others	129.99	147.00	200.00	150.00
Recruitment and Publicity	2,512.13	1,921.26	2,000.00	2,000.00
Newsletter	1,500.67	1,703.30	1,700.00	1,700.00
Scholarship Awards		1,177.00	877.00	
Gratuities				140.00
Miscellaneous	264.43	480.81	200.00	70.00
A.J.O.T. (Cash Revolving Fund, Expenses, Discount and Commissions)	17,674.64	20,731.30	21,000.00	21,000.00
Transfer to Reserve for Scholarship	474.86		100.00	
Deposit on Travel and Insurance	483.00			
Purchase of Bond	500.00	500.00	500.00	500.00
Grant to Educational Fund	3,000.00	3,925.00	3,925.00	6,300.00
Standard Plans	1,128.97			
	$64,893.39	$73,229.85	$71,112.00	$69,700.00
Excess of Income over Expenses	(2,044.33)	6,702.61	65.00	000.00

EDUCATIONAL FUND

	Actual Inc. & Exp. Year ending Aug. 31, 1951	Actual Inc. & Exp. Year ending Aug. 31, 1952	Approved Budget Year ending Aug. 31, 1952	Proposed Budget Year ending Aug. 31, 1953
Balance September 1st.	$ 8,222.11	$ 4,823.96	$ 4,823.96	$ 4,160.86
INCOME:				
From General Fund	3,000.00	3,925.00	3,925.00	6,300.00
Grant from Mrs. Morris for Research		200.00		
Donations etc. (Reserve for 1952-53)		270.00		400.00
Examination Fees	4,390.00	4,730.00	4,000.00	4,500.00
Sale of Reprints	827.99	1,078.67	500.00	800.00
Convention Institute, Previous Year	675.00	763.50	1,600.00	
Current Year		1,207.75		
Bank Interest	90.62	114.52	90.00	50.00
Payment from Schools and Other Sources				750.00
Transfer from Grant Fund, to Pay for Office Services and Consultant Fees		1,500.00		
	$17,205.72	$18,613.40	$14,938.96	$16,960.86
EXPENSES:				
Furniture and Fixtures	$	$ 10.58	$ 100.00	$ 100.00
Cost of Reprints	728.25	760.28	800.00	800.00
Payroll	5,169.39	6,095.76	6,300.00	6,500.00
Consultants Fee	2,314.00	3,006.00	2,500.00	2,500.00
Computations	632.00	259.00	450.00	450.00
Audit	130.00	130.00	130.00	130.00
Committee Expense	249.51	227.72	250.00	250.00
Convention Institute, Previous Year	624.59	477.08	500.00	
Current Year		461.97	500.00	
Examination Expense	343.60	498.46	400.00	400.00
Office Repairs	100.00	36.50	100.00	75.00
Office Supplies	188.13	246.86	250.00	250.00
Postage and Expressage	232.80	158.34	250.00	200.00
Printing	319.62	53.91	350.00	250.00
Rent	900.00	900.00	900.00	900.00
Telephone and Telegraph	254.27	197.88	250.00	200.00
Travel	431.30	332.68	500.00	1,000.00
Payroll Taxes	213.83	291.16	300.00	325.00
Miscellaneous	21.25	5.45	42.00	25.00
Depreciation	65.27	71.80	66.00	75.00
Research		42.00		
Reserve for 1953-54				2,530.86
	$12,917.81	$14,263.43	$14,938.00	$16,960.86
Reserve	4,287.91	4,349.97	.96	

STATEMENT OF A.O.T.A. RESERVE FUNDS

Endowment Fund $18,700.00 (Income only may be used) Yearly Income			$ 467.50
Estimated Cash on Hand, August 31st, 1952			14,500.00
Reserve Funds:			
Investments		$ 3,100.00	
Cash Deposits, N.Y. State Disability Ins.	$ 58.00		
TWA Travel	425.00		
Rent	250.00	733.00	
Reserve for Scholarships		147.61	
Reserve for Depreciation of Furniture		1,767.26	5,747.87
Total Reserve Fund			$20,715.37

GRANT ACCOUNT

	Actual Inc. & Exp. Year ending Aug. 31, 1950	Actual Inc. & Exp. Year ending Aug. 31, 1951	Actual Inc. & Exp. Year ending Aug. 31, 1952	Total Inc. & Exp. Aug., 1950 thru Aug. 31, 1952
Balance September 1st,		$ 7,497.14	$ 1,445.01	
Cash received August, 1950	$12,000.00			$12,000.00
Cash received September, 1951			5,200.00	5,200.00
Cash received March, 1952			3,600.00	3,600.00
	$12,000.00	$ 7,497.14	$10,245.01	$20,800.00
EXPENSES:				
O.T. Consultants				
Travel	$ 768.28	$	$	$ 768.28
Maintenance	784.00			784.00
Fees	1,120.00			1,120.00
Consultant—Psychologist	1,565.00	4,107.00	4,422.00	10,094.00
Computations		336.75	438.50	775.25
Consultant's Expense	21.34			21.34
Office Supplies	17.51	10.71	23.75	51.97
Postage	.30	255.23	224.03	479.56
Printing	138.99	799.43	703.05	1,641.47
Secretarial	82.44	543.01	30.80	656.25
Miscellaneous	5.00		1.10	6.10
Transferred to Education Fund for Office Services and Consultant's fees			1,500.00	1,500.00
Total Expenses	$ 4,502.86	$ 6,052.13	$ 7,343.23	$17,898.22
Balance August 31st,	7,497.14	1,445.01	2,901.78	2,901.78

CONSTITUTION REVISION COMMITTEE

June, 1952

TO THE MEMBERS OF THE A.O.T.A.:

Attached is a copy of the proposed revisions of article II and article VI of the A.O.T.A. constitution. Excerpts from the present constitution are in the column to the left and changes are are in the column to the right.

You will recall that the last action on this was at the 1951 annual conference. The Board recommended appointment of a constitution revision committee following decision of the House of Delegates to table the matter of voting privileges of an associate member until the A.O.T.A. constitution was revised.

An effort has been made to clarify and simplify some portions, to combine others and to eliminate details which are contained in the official organs of the House of Delegates.

The constitution revision committee will appreciate your careful study of these suggested revisions which will be presented to the House of Delegates, the Board of Management and the membership at the annual meeting at Milwaukee, August, 1952.

Sincerely yours,
(Signed) Elizabeth Withers, *Chairman*
Ruth Zieke
Naida Ackley

PRESENT CONSTITUTION
ARTICLE II

Members

Sec. 1. Members shall be divided into six classes: 1. **ACTIVE**: those who are registered occupational therapists in good standing, who are or have been actively engaged in the use of occupational therapy; and when there is a state or regional association recognized by the American Occupational Therapy Association, they must be active members of their state or regional association.

The remainder of Sec. 1 is unchanged.

SUGGESTED REVISIONS
ARTICLE II

Members

Sec. 1. Members shall be divided into six classes: 1. ACTIVE: those who are registered occupational therapists in good standing.

Sec. 2. 1. ACTIVE members and such sustaining members as are eligible for active membership may vote for and be eligible to any office of the Association. 2. FELLOWS may vote in the election of officers and may be elected to serve as officers or Board members. They shall be appointed by invitation of the Board to serve for a period of three years, subject to reappointment. 3. STUDENTS may not vote in the affairs of the Association but may be invited to serve as members of committees without vote. 4. ASSOCIATES shall have no vote in the election of officers and are not eligible to any office of the Association, but may be invited to serve on committees. 5 SUSTAINING members may serve on committees but may not vote for or be eligible to any office of the Association unless eligible to be active members or fellows. 6. HONORARY members may serve on committees but may not vote for or be eligible to any office of the Association.

Sec. 3 is unchanged.

ARTICLE VI

House of Delegates

Sec. 1. A State or Regional Group composed wholly or in part, of practicing registered therapists, and meeting the minimum requirements established by the House and approved by the Board, shall be considered eligible for affiliation with the American Occupational Therapy Association. Active members of affiliating State and Regional Associations eligible for active membership in the American Occupational Therapy Association must become active members of the American Occupational Therapy Association and pay the established membership fee.

Sec. 2. There shall be a House of Delegates to act as a recommending body, to suggest policies, and to present to the Board of Management for action such other matters as shall be brought to *their* attention. It shall meet yearly . . . etc.

The remainder of Sec. 2. is unchanged.

Sec. 3. The House of Delegates shall be composed of delegates elected by the approved constituent State or Regional Associations. Each constituent association shall be entitled to elect one Delegate and an alternate. While both the Delegate and the alternate may attend meetings, only the Delegate or the alternate acting as the Delegate—may vote. The Delegate shall be elected, and notification of his election—with his credentials—shall be sent to the Secretary of the House of Delegates within thirty days after said election. The person so elected must have been a registered occupational therapist and an active member of the State or Regional Association and the American Occupational Therapy Association for more than one year before the date of his election. The Delegate shall serve for three years including the first annual meeting following his election, and shall continue to represent his Association until a new Delegate is elected. He may be reelected for only one succeeding term. At each annual meeting, all Delegates must present credentials, satisfactory to the Committee on Credentials of the House.

Sec. 4 is unchanged.

Sec. 6. One-third of the House of Delegates shall constitute a quorum.

Sec. 6 becomes Sec. 5. The content is unchanged.

Sec. 2. 1. ACTIVE members may vote in the affairs of the Association and in the election of officers and may be eligible to any office of the Association. 2. FELLOWS shall be appointed by invitation of the Board to serve for a period of three years, subject to reappointment. They may vote in the affairs of the Association and in the election of officers and may be elected to serve as officers or Board members. 3. STUDENTS may not vote in the affairs of the Association or in the election of officers and are not eligible to any office of the Association, but may be invited to serve on committees. 4. ASSOCIATES shall have no vote in the affairs of the Association or in the election of officers and are not eligible to any office of the Association, but may be invited to serve on committees. 5. SUSTAINING members may serve on committees and if eligible to be active members or fellows may vote and be elegible to any office of the Association. 6. HONORARY members may serve on committees and if eligible to be active members or fellows may vote and be eligible to any office of the Association.

ARTICLE VI

House of Delegates

Sec. 1. A State or Regional Group composed of a majority of registered occupational therapists and meeting the minimum requirements established by the House of Delegates shall be considered eligible for affiliation with the American Occupational Therapy Association. Active members of affiliating State and Regional Associations must become active members of the American Occupational Therapy Association.

Sec. 2. There shall be a House of Delegates to act as a recommending body, to suggest policies and to present to the Board of Management for action such other matters as shall be brought to *its* attention. It shall meet yearly . . . etc.

Sec. 3. The House of Delegates shall be composed of Delegates elected by the active members of the approved constituent State or Regional Associations. Each constituent association shall be entitled to elect one delegate and an alternate. The terms, procedure for election, qualifications, rights and duties of the delegate and the alternate are embodied in "Formation and Function" and "Constitutional Guide for Affiliated Associations of the House of Delegates of the American Occupational Therapy Association".

Sec. 5. One-third of the House of Delegates shall constitute a quorum.

Sec. 5. becomes Sec. 6 and contains changes as noted below:

Sec. 5. The House of Delegates shall annually elect a Speaker or Presiding Officer, a Vice-Speaker, a Secretary (who shall act as Chairman of the Committee on Credentials) from the group of Delegates who have served as delegates for at least one session prior to election. They shall hold office until the close of the next annual meeting of the House of Delegates. Any Association unable to send a Delegate may be represented by a written certified statement of opinion from the Association covering each item of the agenda. This may be used for guidance and discussion, but does not constitute a vote.

Sec. 6. The officers of the House of Delegates shall be a Speaker or Presiding Officer, a Vice-Speaker and a Secretary. An officer of the American Occupational Therapy Association or a member of the Board of Management shall be ineligible to serve as a House officer. The procedure for election of officers and the duties of officers of the House of Delegates are embodied in "Formation and Function" and "Handbook for Delegates".

Sec. 7. The House of Delegates shall elect for representation on the Board of Management six persons from its membership. Their term shall be two years, three retiring annually.

Sec. 8. Members of the House of Delegates elected to the Board of Management shall serve a two-year term. If for any reason a Delegate serving on the Board is unable to complete his term his place shall be filled by another delegate appointed by the Speaker of the House.

Sec. 7. The House of Delegates shall elect from its membership six representatives to the Board of Management, one of whom shall be the Speaker of the House. Their terms shall be two years, three elected annually and three retired annually. The procedure for election of Delegate Board Members or filling vacancies in Board Membership is embodied in "Formation and Function".

Sec. 7 and Sec. 8 are combined into one section.

AMERICAN JOURNAL OF OCCUPATIONAL THERAPY

As local convention chairman I am going to begin my report by welcoming all of you to Milwaukee and say that we in Wisconsin have enjoyed planning this convention for you and hope you will find it constructive and interesting.

It was interesting to note that as we became engrossed in convention planning, many small activities were temporarily dropped. One was a semi-annual letter to the delegates asking them to encourage our members to use Journal advertisers. Unfortunately this was felt by the advertisers. They did not feel they were getting the reader response of previous years. Therefore I hope you will return and urge members to make a more concentrated effort to support the advertisers that support us.

May I ask you to help the editorial office in the matter of circulation. Please use your business address when possible, as it is less likely to change as often as home addresses.

When sending us a change of address, specify if it is to be a temporary change so that metal plates will not be made until a more permanent address can be given.

When going on a vacation, notify the post office to *hold* magazines because second class mail is *not forwarded* and the magazine is returned to us. We assume that you have changed your address without notifying us and so your plate is put in the dead file.

May I encourage all of you not to be modest. Do not be afraid to write. If your article is not accepted, reasons are given that will help you to meet the standards next time and so, for the prestige you gain, your hospital gains and your profession gains, please write. Thank you.

Respectfully submitted,
(Mrs.) Lucie Spence Murphy, O.T.R.
Editor.

SUB-COMMITTEE ON SCHOOLS AND CURRICULUM

Representatives of 24 schools of occupational therapy, including the Army program, attended the meeting. The University of Kansas was not represented.

Miss Martha Matthews, educational secretary, presented a statistical chart comparing ratings of the February, 1952, registration examination clinical training reports with the June, 1952, reports. The table indicated a lower, and possibly more accurate, scoring in June than in February. Discussion followed on changes of the rating form. It was recommended that specific action concerning this be taken after the report of the sub-committee on clinical training at the meeting of the education committee on August 10, 1952, 8:00 P.M.

Miss Matthews again reviewed the cost of special services the education office renders schools. After hearing suggestions, from various members of the sub-committee, on ways schools might meet the cost, a poll was taken to indicate whether colleges and universities preferred a type of membership in the A.O.T.A. or being billed for services. Twelve wanted to be billed. Eight indicated either way. Three could not speak for school. One wanted institutional membership if possible.

A recommendation was made that a dual plan be set up explaining the fees to be charged for the education office services and the cost of a possible membership fee, a letter of explanation to be sent to school directors for approval by deans before any billings are made. (Approved by the education committee).

A recommendation was made that office expenses for services to schools be included in the estimate of cost. (Approved by the education committee).

A recommendation was made that the letters be sent to the school directors, as soon as practicable, explaining the two alternatives of billing or fee, so that services may be continued. (Approved by the Education Committee).

A recommendation was made that the education committee recommend to the Board of Management that reprints be sold not at cost but that office overhead and

handling be included in the price of reprints. (Approved by the education committee).

The ever present problem of training occupational therapy aides was not discussed. The education committee has recommended that such training be given by the institution. Accepted and good programs of this type are functioning in psychiatric and tuberculosis hospitals. Texas is in the process of developing a program of occupational therapy aide training which they would like to present to the education committee.

Moved and seconded that the education office should immediately study the method of grading the clinical training reports and effect a change as soon as possible. (Approved by the education committee).

Respectfully submitted,
Borghild Hansen, O.T.R.,
Acting Chairman.

SUB-COMMITTEE ON CLINICAL TRAINING

Seventeen members and an unusually large number of guests attended the sessions of the sub-committee on clinical training.

The following items on the agenda were discussed and action taken as indicated:

1. Scheduling of students in clinical training: there was discussion of the tendency of some school directors to wish to make clinical training commitments not only the one year in advance as previously recommended by this committee, but also to do so as far as two years in advance. There was agreement that this is particularly advantageous in those centers where training in several areas is being given and that in other centers this has created no problem. Therefore the sub-committee wished to bring this fact to the attention of all school directors so that they may be aware of this trend which is developing. This should in no way effect the regularly scheduled commitments, nor is this statement intended to bring about early scheduling as a definite recommendation.

2. Revision of the *Inquiry Form* which is now in use for unusual requests for student affiliations:

a. In the few schools where it is currently being used it is proving most successful for both schools and clinical training directors.

b. There is at least one school using this form not only for these irregular requests for clinical training assignments but also for regular commitments and this again is very satisfactory to all concerned in that it saves correspondence and provides a record for a file on each student at the training center.

c. The changes in the attached form have been recommended and the new one will so read. (This was approved by the education committee meeting in joint session.)

d. It was also recommended that it be brought to the attention of the schools that a citizenship requirement is a problem in some states and that if a student is a citizen of a foreign country it be so indicated under "Comments" on the *Inquiry Form.*

3. Clinical training directors' meetings: the sub-committee on clinical training wishes to express its appreciation to the sub-committee on schools and curriculum for the time and effort spent by the schools in arranging clinical training directors' meetings.

We again request that minutes of such meetings be sent not only to those clinical training directors who attended but particularly to those directors who were unable to be present.

Again this year there was a discussion as to the value of these meetings with all present agreeing that they should be continued.

4. Form used by students for evaluation of clinical training: under this item considerable discussion brought out the following points pertinent to our recommendation which will follow:

a. The continued use of this form was unanimously approved by the committee because of its valuable help in improving training programs.

b. It was felt that the present procedure of a yearly return of these forms is not frequent enough to allow for the best utilization of these evaluations in that modifications cannot be effected as soon as clinical training directors would like.

c. A poll of those present showed that for the period from July, 1951, through June, 1952, only 50% had received any reports.

d. Considerable thought was given to the students' responsibility in the use of this form. It was felt by the group that this evaluation is one of the best tools for learning objective reporting.

e. The sub-committee on clinical training therefore wishes to present the following recommendations: (1) That the use of the form be continued. (2) That the student be required to return the form to the school within two weeks after completion of the training period. (3) That these forms then be returned to the clinical training center immediately. (4) That the student's signature remain affixed. (5) That the following be added under "Remarks"; (a) What did you contribute to this affiliation? (b) What did you gain?

When this was presented to the education committee the following recommendation wa substituted for e 2, e 3: The use of the form be continued but that it be filled out by the student before leaving the affiliation and that, after the rating form has been considered, this then be discussed and evaluated with the student. One copy would then be retained by the clinical director and the other copy would be forwarded by the director, not the student, to the school along with the rating of the student. This ruling to become effective January 1st, 1953.

5. In an attempt to clarify the problems resulting from overlapping in the field of G.M. & S. and physical disabilities we were confronted with many factors, particularly the problem of terminology. The discussion grew out of a report made by Miss Angeline Howard, chairman of a special study group in general medicine and surgery. No conclusions were reached. The special study group will continue and will report at a later date.

6. Evaluation of occupational therapy departments and clinical training centers: a report from Miss Spackman stated that Part I of the *Evaluation of Occupational Therapy Departments* will be sent out on a test run and will then be evaluated and revised accordingly. Part II was presented to the sub-committee on clinical training. It was recommended that Part II be sent out on a trial run to 50 hospitals to be selected by the committee. Some modifications and changes were suggested by the committee. Some modifications and changes were suggested by the committee which will be considered by Miss Spackman and her committee before the trial run is made. Part III B was reviewed and some changes suggested. The committee recommended that the changes made be incorporated and that the form be sent, at the discretion of the committee, to school directors.

7. A report on clinical training reports for 1952 was submitted by Miss Matthews showing first gross breakdown of ratings by area. Miss Matthew then reported it was the intention of the education office to study the individual training center's reports. This would give the office opportunity to point out any irregularities or errors in the use of the form to the indivdual directors. The clinical training committee was in complete agreement with this plan and voted its wholehearted approval.

8. Student manual: Discussion on this manual revealed a unanimous approval of its value and desire for its continued use. Since a new printing is now necessary the the following changes were suggested:

a. Printing on both sides to reduce both weight and cost.

b. Page 33, last paragraph of *C*, last sentence, change to: "as a registered therapist you are eligible for active membership in both local and the national association."

c. Page 36, history chronology to be brought up to 1952 and the paragraph following it be rewritten eliminating the negative intonation. (This to be done if cost permits.)

d. Page 38, dues changed to read $10.00 instead of $8.00.

e. Changes in second paragraph of "Student Report on Clinical Training" to conform to action taken in item 4 of agenda.

f. Other suggestions which may add to ease in use: make title pages of different colors; use posts or fasteners instead of rings.

g. It was also suggested that the Newsletter be used to list corrections in the manual and also to keep it up to date.

All the above were submitted to the education committee meeting in joint session and all were accepted by consent.

9. Consideration of a manual for directors. This is not to be confused with the present directors manual but rather would be one which would give teaching aids. The committee felt it best not to consider this at the present time.

10. Establishment of an apprenticeship system for first year graduates who would work in centers recognized for their methods and practice of occupational therapy. The committee felt that no more can be done than is already recommended in the student manual page 34, last paragraph.

11. Committee membership: the sub-committee on clinical training, after considerable discussion, voted to increase the membership to 40 members on a rotation basis, each to serve four years. In naming members, the chairman will continue to consider the several factors of geographical location, occupational therapy specialty, ability to attend meetings with some degree of regularity, and to have all schools represented by one or more clinical training directors.

During this discussion emphasis was given to the fact that any occupational therapist is always welcome to attend these sessions as a guest.

Respectfully submitted,
Ruth Grummon, O.T.R.
Chairman.

EDUCATION COMMITTEE

Joint Session: Sub-Committee on Schools and Curriculum and Clinical Training

The regular meeting of the education committee in conjunction with the annual meeting of the A.O.T.A. was held on the morning of August 9, 1952, at the Hotel Schroeder, in Milwaukee. There were representatives of twenty-one of the schools present and seventeen clinical training mmbers, Dr. Arestad, Dr. Licht, Miss Helen LeVesconte of Toronto, and a number of other guests. After introduction of members it was announced that all previously established O.T. schools are now fully approved and that the new Army school and a new school in the Galveston Medical Branch of the University of Texas have been given initial approval by the A.M.A.

Brief reports were given by Miss Fish and Miss Matthews on the work of their respective offices. (See published reports)

Lt. Col. Helen R. Sheehan who has replaced Lt. Col. Ruth Robinson in the Office of the Surgeon General, U.S. Army, reported that the W.M.S.C. has fifteen affiliate students training in five hospitals (Letterman, Fitzsimmons, Walter Reed, Brooke and Valley Forge). Captain Wilma West reported that the new Army school for O.T.'s is to open on November 20 at Brooke. An advanced standing course (college graduates) seventy weeks in length (34 didactic, 36 clinical training, 40 hours per week) is being offered with a hoped-for-enrollment of twenty students.

Miss Mary Beach reported training of 179 students from 23 schools in 17 V.A. hospitals. A most successful workshop for clinical training directors has been given and another is being planned.

Miss LeVescont described the combined occupational therapy and physical therapy course given in Canada. The program, started in 1949, required a drastic cut in the occupational therapy curriculum. The time for occupational therapy theory was cut to five hours, which is, however, because of students' protests, gradually being increased. Clinical practice was reduced to one full month in occupational therapy and physical therapy each, though some hours of practice are given in the second year (270) and in the third year (470). Some students have voluntarily taken longer clinical practice. Graduates will belong to both physical therapy and occupational therapy associations and the fee will be split. The Canadian occupational therapists have come to believe in the value of the combined course and think that the medical content is excellent but clinical practice is inadequate. In general, though the students are less mature than formerly the occupational therapists feel that the better medical background is proving its value and that the graduates will eventually become satisfactory workers. The enrollment of both physical therapists and occupational therapists together is at present less than the former total of occupational therapists alone.

There was considerable discussion which brought out the fact that the course places a considerable burden of teaching, supervising and planning upon clinical training directors; that, while that graduate is trained in both physical therapy and occupational therapy, save in small hospitals she will not do both; that all students get training in treatment of industrial accidents and in psychiatry, but that T.B. and pediatric experience is very limited; that no men students are accepted, and that specialization and preparation for senior posts must be done after graduation. The program is still in an experimental stage and will probably undergo considerable modification.

Sister Jeanne Marie presented a report of the sub-committee on graduate study. (See published report)

Various occupational therapists were asked to interview deans of 15 graduate schools. The consensus of replies were to the effect that such courses would be difficult to establish, save for persons already having a B.S. degree in occupational therapy and that occupational therapists should seek degrees in allied fields such as anatomy, psychology or human development. There was active discussion following the report, but not specific conclusions were reached.

Miss Henrietta McNary presented a fifteen page mimeographed report of the committee on the study of treatment media. The activity analysis indicated that the six major activities used in clinical training programs are woodwork (including plastics), sewing and needlework, weaving, leatherwork, recreation (including religion), decorative and fine arts. Self-help activities placed seventh on the list. Specific recommendations were made as follows:

Selection and Teaching of Techniques or Skills

1. Concentrate on the thorough knowledge of a few major crafts and condensed information on a range of minor crafts.

a. Develop sense and application of good basic design, through knowledge of fundamental techniques and appropriate finishing of articles.

b. Teach students to follow printed instructions more efficiently to encourage acquiring additional skills after graduation.

c. Emphasize theory of O.T. in craft processes (adaptations to meet therapeutic needs, systematized procedures as testing techniques, etc.)

d. Select range of minor crafts to replace antiquated crafts with those in modern demand requiring simple processes.

2. Offer greater emphasis on analysis and performance of activities of daily living.

3. Offer increased understanding of the techniques of childrens play, use of toys and appropriate crafts for children.

4. Emphasize practical range of recreational activities.

5. Stress theory and possible practice of prevocational activities and hospital industry in their relation to formal job performance in employment.

6. Require practical typing proficiency.

Suggestions were made for developing students skill in teaching, for strengthening theory of occupational therapy by increased factual knowledge, and for crystallization of the students general concept.

The report is an excellent one with much valuable material for consideration.

Miss Erna Rozmarynowski reported as follows the conclusion of a committee appointed to study the possibilities of shortening the B.S. degree course to four years.

The majority of the schools favored shortening the course, but opposed shortening of clinical practice. It was also thought that there should be no deletion of academic subjects; therefore, any cut would have to be in the skills. Academic credit for clinical practice is already given in a number of the schools, so this would not present too serious a problem.

The committee found wide discrepancies in the hours devoted to the various skills. It was, therefore, suggested that the number of semester credits required be cut from 25 to 15 with a core curriculum of 9 semester credits covering woodwork, design, general crafts, weaving and sewing, and 6 additional credits covering ceramics, printing, metalwork, fine arts and recreation.

There was active discussion emphasizing the need to teach skills better; that clinical training supervisors are willing to teach minor skills, but have already reached the saturation point in this subject. Dr. Licht questioned whether shortening the course would improve recruitment and advised perpetuation of study of the curriculum and concentrated effort to get Master's degrees. Dr. Arestad advised the shortening with the fifth year used for attaining the Master's degree by those who wished to do so.

The consensus was that those schools which were able or willing to shorten their courses should submit tentative curricula to the education committee to be reviewed at the mid-year meeting. The possibility of pilot courses was suggested in order to determine results before drastic changes are effected.

Miss Messick, Miss Rozmarynowski and Miss Rood reported analyses of the special courses, given in their repective schools, for students advanced in skills. The consensus was that these had proven more than worth while and that other schools should be urged to inaugurate such courses and to recruit students from younger age groups.

Reports from a number of schools in regard to the curriculum advanced by the advisory committee on education of the Council on Physical Medicine and Rehabilitation of the A.M.A. were summarized. The curriculum proposes identical basic courses for physical therapists and occupational therapists, and for the occupational therapists, greatly rdeuced psychology, psychiatry, theory of occupational therapy, skills and clinical practice. The program would require almost four years of study but would carry no degree.

Various individual doctors and members of advisory committees of the several schools expressed almost unanimous disapproval of the proposed course in that the emphasis was too much on physical disabilities to the virtual exclusion of psychiatry, tuberculosis and pediatrics. It was recommended that all groups of physicians utilizing occupational therapy (especially the American Psychiatric Association) should be consulted in regard to the education of occupational therapists. This recommendation was approved for action by the education committee.

The question of recognition of occupational therapy assistants trained in hospital courses was brought up by Miss Naida Ackley but, because of previous action taken by the Board, was not discussed.

The possibility of night and summer courses was mentioned. It was suggested that this question be referred to the sub-committee on schools and curriculum.

The meeting was adjourned.

* * * * *

A second joint meeting of the education committee was held on Sunday evening, August 10, to consider recommendations of the sub-committees. Subjects discussed and actions taken are recorded in the minutes of the sub-committees (see published minutes). Miss Fish presented data in regard to institutes sponsored by the American Hospital Association. The suggestion that such an institute be promoted (a possible subject: "Organization and Administration of Occupational Therapy Departments') met with approval.

Respectfully submitted,
Helen S. Willard, O.T.R.
Chairman.

INTERNATIONAL RECIPROCITY

I. The registration committee recommends that reciprocity of registration on the basis of examination be established with foreign occupational therapy associations, through the following procedure:
   A. That in the opinion of the registration committee the curriculum of the schools of occupational therapy be comparable with those in the U.S.A.
   B. That such reciprocity shall be granted on an individual basis only, in accordance with the following requirements:
      1. The occupational therapist must be a graduate of an approved school of occupational therapy (accredited by the country's medical association, occupational therapy association or other qualified professional organization.
      2. The occupational therapist must be recommended by the school director.
      3. The occupational therapist must be qualified in all areas of occupational therapy.
      4. The occupational therapist must be a member in good standing of his own association.
      5. Applicants will be classified according to the following:
         a. Student therapist (one who enrolls in the clinical training program of an American occupational therapy school).

1. Twelve months of clinical experience required.
2. Experience to be secured at various training centers in accordance with A.M.A. Essentials (periods of two months or more).
3. Clinical training reports to be submitted as for our students.

b. Graduate therapist (one who is seeking advanced study under a program planned by an American occupational therapy school)
1. Nine months field experience required.
2. Experience to be secured in periods of 2 months or more.
3. Clinical training reports to be submitted for each affiliation.

c. Employed occupational therapist (not under the jurisdiction of an American occupational therapy school).
1. Twelve months of work experience in an approved occupational therapy department required.
2. Experience to be in one occupational department under the supervision of an O.T.R.
3. Work report to be submitted in place of clinical training report.
4. The applicant must be recommended by the O.T.R. to write the registration examination.

II. The registration committee recommends that reciprocity of registration without examination be established with foreign occupational therapy associations, through the following procedures:

A. That the association be a member of the World Federation of Occupational Therapists.

B. That in the opinion of the registration committee the curriculum of the schools of occupational therapy be comparable with those in the U.S.A.

C. That for at least 5 years the association shall have administered an examination for occupational therapists which is equivalent to that given for registration in the U.S.A. That evidence of the type, level and scope of the examination shall be presented to the A.O.T.A.

D. That such reciprocity shall be granted on an individual application basis only, in accordance with the following requirements:
1. The occupational therapist must present evidence of successful completion of an approved course in occupational therapy.
2. The occupational therapist must have successfully passed the occupational therapy qualifying examination of his country.
3. The occupational therapist must be a full voting member of his association or of a classification comparable to that of a registered therapist of A.O.T.A. and be recommended by his association.
4. The occupational therapist must be qualified in all areas of occupational therapy.
5. The occupational therapist must have had 24 months post graduate working experience, 12 months of which must have been spent in a recognized occupational therapy department in the U.S.A. under an O.T.R. who is an active member of the A.O.T.A.
6. The occupational therapist must be recommended for reciprocal registration by the O.T.R. under whom he has worked.
7. All requests for reciprocity must be submitted to the registration committee with a $20 fee. If the applicant is not accepted $10 will be returned.
8. Upon the granting of reciprocal registration, the occupational therapist may wear the registry emblem and use the letters O.T.R. after his name in conjunction with the letters of his original qualification. He may be listed in the A.O.T.A. registry.

III. It is recommended that once a foreign therapist is registered, through such reciprocity, annual re-registration shall be maintained in accordance with the current A.O.T.A. regulations.

COMMITTEE ON GRADUATE STUDY

In the first report of this committee (Chicago, March, 1952) seven steps of procedure were specified. (Exhibit I) Of these seven steps, immediate consideration of No. 4 (g) and (h) was urged in a letter to the chairman on June 18. By July 3, the six other members of the committee and five consultants had been sent copies of the course now offered to advanced standing students in fourteen schools of occupational therapy. These 12 persons were asked to interview the deans of 15 graduate schools. (Exhibit II) Two questions in particular were asked: (1) What possibility there would be of securing Master's degree recognition for the advanced standing course in occupational therapy in that graduate school, and (2) What other opportunities for earning a Master's degree would be recommended for occupational therapists holding B.A. or B.S. degrees from other institutions. Replies have been received from eleven of the graduate schools, to date. Statements concerning eight of the replies are recorded in Exhibit III (the first two of three mimeographed pages herewith appended).

Some of the issues apparent to one who analyzes these returns are these:

1. Should the anticipated number of registered occupational therapists educated at Master's degree level be: Many, all, half, or few? Why?

2. Which kind of Master's degree should be preferred for occupational therapists: Professional (MOT) or liberal (M.A.)? Why?

3. What rating should the graduate school have, at which occupational therapists study for Master's degrees? Why?

4. Should there be only one Master's degree level course, or different courses, depending on whether the applicant has, or has not, had occupational therapy as an under-graduate, either for a B.A. or a B.S. degree, or for a diploma?

5. To what extent should the present under-graduate courses in occupational therapy be retained as they are, or modified, to suit the requirements of the Master's degree program(s)?

In deciding the issues listed above, the likely effect should be considered:

(a) On actual patient benefit, both quantitatively and qualitatively,

(b) On recruitment to meet present needs of practicing and teaching occupational therapists,

(c) On the democratic concept of service to suffering humanity.

Had there been time, an attempt would have been made to invite all twenty-six schools of occupational therapy to tap the trend of thought among their graduates concern-

ing the worth to them of graduate study. In the short interval left before this meeting, only 14 schools were asked to send out copies of the check list used first as a form for summarizing results, by Columbia. Eight of these schools responded with at least partial summaries, and two others reported estimates.

(A tabulation of these comparative returns appears as the third of the three mimeographed pages making up Exhibit III of this Report). Thus, over 800 alumnae were contacted and within three weeks replies were received from well over half that number. Of those who replied (approximately 350): 210 have taken courses since graduation; 235 want more study; 22 have Master's degrees; 126 contemplate getting a Master's degree.

The areas within which these alumnae have been continuing their study, or would like to continue, are surprisingly varied. The outlook is highly encouraging. With a little more money saved and a little more time "made", occupational therapists can be depended on to lift themselves, by good, wholesome study to Master's degree programs and the necessary degrees for equal status on college and university faculties. The intellectual adventure will be engaging, and the reward well worth their best efforts.

The committee on graduate study have much work left to do. It awaits direction.

Respectfully submitted,
Sister Jeanne Marie, O.T.R.,
Chairman.

EXHIBIT I.

Seven Steps of Procedure for The Committee on Graduate Study (Specified March, 1952)

1. To bring up-to-date (a) the investigations made in pursuit of objectives one and two of the earlier committee on graduate study (through the education office of A.O.T.A.) (b) The list of registered occupational therapists now holding higher degrees (furnished by the education office of A.O.T.A. in 1950)

2. To assemble for comparison, study, and recommendation for best offerings, the course requirements, costs, etc.

(a) for Master's degrees in related areas, especially in those universities offering part-time assistantships as staff occupational therapists, while opportunity is taken to spend part-time in graduate study: Illinois, Ohio, New Hampshire, Kansas, etc.

3. To inquire about recent trends in graduate study at the strongest graduate schools in the country, and to weigh with them the possibilities of developing further the graduate study desired, and now engaged in, by occupational therapists.

4. To present, in ways approved by respective administrators, the bases for recommendation to the education committee for approval, endorsement or accreditation, such post-graduate and refresher courses as those now offered.

(a) at Columbia University
  (1) through the Coordinating Council for Cerebral Palsy
  (2) through the occupational therapy department for senior occupational therapists in state mental hospitals, requested by Miss Virginia Scullin

(b) at Georgia Warm Springs and at the University of Southern California as short-term sequences, particularly of Southern California as short-term sequences, particularly for the treatment of poliomyelitis

(c) at Cockeysville, Maryland (Children's Rehabilitation Institute) for the treatment of cerebral palsy patients

(d) at Richmond Professional Institute and at St. Louis University for in-service professional development of state hospital therapists

(e) at the Philadelphia School of Occupational Therapy for treatment especially of physical disabilities

(f) at the Orthopedic Hospital in Los Angeles

(g) at the 13 schools of occupational therapy now offering advanced standing courses

(h) at Captain West's new school (MFSS) at Brooke General Army Hospital, Texas

5. To work in close cooperation with the other committees of A.O.T.A. and with the education office, in particular with:

(a) the new committee on special studies, Miss Margaret Rood, chairman
(b) the study committee on treatment media, Miss Henrietta McNary, chairman
(c) the new study committee to determine the content of an acceptable course which will prepare a person to function in one field of occupational therapy, Miss Beatrice D. Wade, chairman

6. To expand or limit the work of the committee on graduate study as need arises

7. To extend invitations to membership in the committee to persons who express interest in working to realize its purposes

EXHIBIT II.

Graduate Schools Inquiry

Committee Members	*Graduate Schools*
Miss Marguerite Abbott	New York Unviersity
Miss Genevieve Anderson*	University of Minnesota
Mr. Ronald Beals	University of Southern California
	University of California (Berkeley)
	University of Washington (Seattle)
Mrs. Jeanne Carroll Donlon	University of Chicago
	University of Illinois
Miss Marion Easton	Tufts University
Mrs. Katherine Habel	University of Michigan
	Western Michigan College
Consultants	
Miss Marie Louise Franciscus	Columbia University
Miss Barbara Locher	Ohio State University
Miss Clare Spackman	University of Pennsylvania
Mrs. Fanny Vanderkooi	Texas State College for Women
Captain Wilma West	University of Texas

*Because Miss Anderson was in Europe, Sister Jeanne Marie interviewed Dean Theodore Blegen at the University of Minnesota.

STATEMENTS CONCERNING POSSIBLE MASTERS DEGREE RECOGNITION FOR PROPOSED CURRICULA IN OCCUPATIONAL THERAPY

At the University of Chicago Graduate School, Dean Anderson and Mr. Robert D. Hess advised that starting new courses and divisions for a Master's degree in occupational therapy would be too costly and too demanding of personnel at the present time and that funds for this purpose would not be available for years, at the University of Chicago. They did not agree with the Dean of the Medical School of the University of Minnesota that the lack of textbooks would be a drawback. As an alternative, at the University of Chicago, they advised that occupational therapists be encouraged to enroll for Master's work in *Human Development*, which would include anatomy, neurology, psychology and psychiatry to show how the human being develops mentally, physically and socially; research projects could be arranged for in the clinics of the University.

At the University of Illinois, Assistant Dean Milan Novak urged the distinction between two types of graduate degrees: (a) professional-MOT- and (b) Master of Arts or Master of Science. He saw no reason why Captain West's list of courses could not be acceptable for an MOT; provided their content was on *graduate* level (which would

require two years, rather than one). He cautioned against using the term, M.A. (or M.S.) in O.T. and insisted that a degree is worth only what the school from which it is received is worth. From some schools, a Master's degree might not be worth the paper its official notification was written on. For occupational therapists who have earned their B.S. (or B.A.) degree with a major in occupational therapy, both Dean Anderson and Dean Novak recommended that a Master's degree be taken in a related field which has its curriculum already approved for such distinction: e.g., in anatomy for those interested in physical disabilities; in psychology for those most interested in psychiatry. In support of this recommendation, Miss Beatrice D. Wade, O.T.R., cited possibilities of graduate work in related fields on the Urbana campus of the University of Illinois and instances of fine cooperation of doctors on the staff at Research and Educational Hospital in Chicago in sponsoring research for the master's thesis.

—Information contributed by Jeanne Carroll Donlon, O.T.R., Member of the Committee on Graduate Study

At the University of Michigan Graduate School, the Dean has been asked to evaluate for recognition by way of a Master's degree in occupational therapy three patterns besides Captain West's pattern of courses: one example is: For O.T.R.'s who prefer to work with mental patients:

Courses	*Semester Hours*
Medical lectures	2
Psychology	2
Neurology	1
Psychiatry	4
Group Therapy and N.P. Theory of O.T.	3
Rehabilitation (N.P.)	4
Job Supervision	2
Vocational Guidance	2
Administrative Polices	2
Electives	
Music	
Recreation	
Literature	
Thesis or electives	6
	32
Creative and Manual Skills (No credit)	12

At the University of Minnesota, Dean Theodore Blegen has given notice that no Master's degree course can at present be offered in occupational therapy, because of limitation of funds, of space, and of personnel.

At the University of Southern California, requirements of the graduate school are very similar for all Master's degrees. For the Master's in occupational therapy, they include:

(1) The applicant must have a bachelor's degree and have been graduated from an approved school of occupational therapy.

(2) The graduate student must make a satisfactory showing on the graduate record examination. (By action of the council on graduate study and research).

(3) The graduate student must petition for, and have been granted, candidacy.

(4) The candidate must have completed 14 semester (graduate) units in occupational therapy plus four semester units of thesis work plus 10 units of approved electives, 4 of which must be graduate level, the remaining 6 may be of upper division level.

(5) The thesis must be approved.

". . . recognized degrees are granted only by schools, colleges, or universities that have met certain formalized standards of the Association of American Universities and have indisputable proof of such recognition." (Whether or not an institution of higher learning is approved by the Association of American Universities is stated in *Lovejoy's Complete Guide to American Colleges and Universities.* According to the copy published in 1948, Simon and Schuster, N.Y., the University of Southern California and the College of St. Catherine, Tufts in Boston and New York University are thus approved and are first category institutions of learning. Baylor University in Texas is approved by the Southern Association of Colleges but not by the Association of American Universities and is therefore rated as second category. Both the Texas State College for Women at Denton and the University of Texas are first category.) "One requisite of the Association of the American Universities is that the student must pass a graduate record examination in the major subject before candidacy is granted." . . . "There probably is no law—State or Federal—to prevent any degree being conferred by any unrecognized educational unit," but what would such a degree be worth?

—Information contributed (and supplemented by S.J.M.) by Ronald G. Beals, O.T.R., Member of the Committee on Graduate Study, July 9, 1952.

At Texas State College for Women, the Dean of the Graduate School has advised that no recognition would be given the courses listed by Captain West, for or toward a Master's Degree "because it is not built on occupational therapy, but on related fields . . . Teachers Training Schools would need a board of management to approve graduate work, whereas private schools can give advance degrees when they wish. . . . Texas State College for Women would never be allowed to count it as graduate work."

—Information contributed by Fanny B. Vanderkooi, O.T.R., Consultant to the Chairman of Committee on Graduate Study, July 28, 1952.

At the University of Pennsylvania, "In regard to the attitude of this University toward the certificate course on a graduate level, I believe I can safely say that they would only consider it on a high academic standing and with an adequate research program. One of the problems would be to find the occupational therapists with Ph.d.'s!"

—Information contributed by Clare S. Spackman, O.T.R., Consultant to the Chairman of Committee on Graduate Study, July 21, 1952.

At Columbia University, "our feeling is that we cannot offer a Master's degree for less work and coverage than is given to our students who receive the Bachelor of Science Degree. The question immediately arises: what would be offered to the Bachelor of Science people who want to continue their study and earn their Master Degree, when they have already covered far more material in professional study than the Advanced Standing students. It would seem that either we would have to discontinue our undergraduate program or insert many more requirements in the graduate program."

—Information contributed by Marie Louise Franciscus, O.T.R.

REPORT OF RECRUITMENT AND PUBLICITY COMMITTEE

We have continued to be without a national chairman throughout the year which has been a most unfortunate situation. However, the state chairmen are to be commended for the excellent continued action in many states as evidenced through requests for materials and notices sent to us of press, radio, TV, exhibits and other forms of publicity. Also, for their cooperation in setting up and providing personnel coverage for A.O.T.A. exhibits in various regions.

Following recommendation of the Board at the mid-year meeting, the A.O.T.A. office undertook coordination of the program for the remainder of the year. (1) a letter went out in April to all state chairmen announcing the appointment of three regional co-chairmen, reviewing the background of our recruitment program for benefit of new local chairmen and describing particular activities to

be carried out. (2) Shipment of recruitment materials to all state chairmen (45 total) for distribution in their area. Approximately 50,282 pieces of literature were sent. The additional $1,000.00 allocated to recruitment and publicity, in the revised budget, made possible this replenishment of our materials. (3) Listing of state chairmen in May Newsletter to acquaint all members with their local source of supply. (4) Provided *Request Forms* for chairmen to indicate additional materials desired. These have been utilized by several states. (5) Provided *Report Forms* to summarize year's activities.

Reports received from 23 of the 46 state recruitment chairmen (50%) were summarized by Mr. Harry Kromer, eastern co-chairman, and presented the following activity:

1. Canvass of high schools and colleges—4,727 pieces of literature were utilized.
2. Speakers bureau—298 speaking engagements were filled before an estimated audience of 11,318.
3. Radio—29 broadcasts and 5 television programs were filled.
4. Newspaper publicity—99 news stories were published. These included photographs of exhibits, short articles expressing need for therapists, full page spreads, etc.
5. Career days—15 states reported invitations to participate in career days.
6. Window displays—10 displays were reported.
7. Library contacts—11 contacts were established.
8. Vocational guidance personnel contacts—16 chairmen reported such contacts. Two chairmen furnished exhibits and shared space with other agencies as a result of these contacts.
9. Organizational contacts—13 contacts were reported with groups such as the Y.W.C.A., Mental Hygiene and Health Associations, the American Red Cross Chapters, Girl Scouts, Business and Professional Women's Clubs, Community Councils, etc.
10. Slides and films—3 chairmen reported available slide series for recruitment and publicity.
11. Exhibits—these are being extensively developed with a variety of formats.

Excellent suggestions were made by the state associations for future plans and new ideas utilizing still more effectively, the channels of communication, i.e. press, literature, radio and television, exhibits, agency contacts (Parent-Teachers, National Education Association, fraternal organizations), etc.

Acknowledgement and thanks are extended to the co-chairmen, Mr. Harry Kromer, Major Ruth Robinson, Capt. Myra McDaniel, and Miss Shirley Bowing for their help this year. We look forward to a good year ahead.

Respectfully submitted,
Marjorie Fish,
Chairman, Pro-Tem.

THE REGISTRATION COMMITTEE

The Registration Committee met eleven times during the year 1951-52.

Examinations for the two administrations were prepared in the customary manner. This consisted of reviewing the questions in relation to the analysis data to determine whether the items were adequate, needed to be rewritten or deleted. Making the necessary replacements requires reviewing and editing of a number of items before a selection is made. Because it is so difficult to obtain good questions in a number of areas, and as there is still the need to complete the fourth part of the examination, the drive for items continues.

The examination was written in 35 different places in February and in 36 in June. The latter included, other than the schools of occupational therapy, Honolulu and Hilo, Hawaii; Rio Piedras, Puerto Rico; New Orleans, Louisiana; Asheville, North Carolina; Buffalo, New York; Marquette, Michigan; Pittsburgh, Pennsylvania; and Syracuse, New York. The total number of examinees for the year is 469, 204 in February and 265 in June. Included in the June group were applicants from Israel, Scotland, Canada, Australia and Denmark.

Date	Number of Examinees	Part I Mean	Part I Sigma	Part II Mean	Part II Sigma	Total Mean	Total Sigma	Correlation of Part I & Part II
February 1950	186	*84.3	10.7	94.3	12.0	178.2	21.0	.69
June 1950	204	*83.7	12.0	87.3	13.6	170.2	24.3	.79
February 1951	203	92.1	13.2	*87.2	12.4	179.3	24.2	.80
June 1951	235	90.5	12.5	*89.0	11.6	179.2	22.8	.79
February 1952	204	*91.3	12.5	92.3	12.8	183.3	23.4	.81
June 1952	265	*89.6	12.1	93.9	13.0	182.9	23.9	.71

*"New" part introduced in February 1950.

Figure 1

The statistical table (Figure 1) permits comparison of the 1952 examinees with those of the two previous year.

The stability of the registration examination continues. The variation in the mean for June, 1952, with a drop of two points is explained by the inadvertent inclusion of two items that were answered correctly by almost all the participants (100% items). The spread in scores remained relatively constant during the year. The correlation between scores obtained in parts I and II dropped in June but it is still sufficiently high. As the content coverage is not identical in the two parts the correlations will record the variation. A definite attempt is made by the committee to prevent duplication in the various parts.

Following the action of the Board of Management upon the recommendation of the registration committee, invitations were extended to five doctors to participate as consultants on the main disability areas. Affirmative replies have been received from two, refusals from two because of other commitments, while correspondence continues with the fifth.

As registration is basic to active membership in the American Occupational Therapy Association, recommendations relative to international reciprocity have been submitted to the Board of Management. The resulting regulations will be published in A.J.O.T. as they are of far-reaching interest.

The committee has decided policy matters and considered special requests as well as executing the routine tasks of reviewing and editing of new items and analysing the examination following each administration.

It is with sincere appreciation that we extend our "thank yous" to the industrious item writers without whose able assistance there would be no examination.

Respectfully submitted,
MARTHA E. MATTHEWS, O.T.R.,
Chairman.

WORLD FEDERATION OF OCCUPATIONAL THERAPISTS

The first step in forming an international organization of occupational therapists was made at the A.O.T.A. convention in Detroit, in 1949. The need of such an organization was emphasized by requests from countries for assistance in starting occupational therapy programs. These were being referred to other organizations, such as the International Society for the Welfare of Cripples, and not to individual occupational therapy associations. At that time the Board approved in principle the formation of a world association. The A.O.T.A. took the initiative of writing to the other occupational therapy associations.

In June, 1950, Miss West attended the occupational therapy conference in London, at which there were representatives of 24 countries. Although there are only ten occupational therapy associations, there is embryonic occupational therapy or some occupational therapy in a number of countries; for example, India, where there is a school of occupational therapy, but as yet no association. At the London conference it was agreed to have a preparatory meeting in conjuction with the meeting of the Society for the Welfare of Cripples in Stockholm, in September, 1951.

Miss Elizabeth Clark, who was working in England at the time, represented the A.O.T.A. at this meeting. As a result of this meeting a preparatory commission was called to meet in April, 1952, in England.

A committee had been appointed by the Board of the A.O.T.A. to assist in the development of plans. The committee members were especially selected for their knowledge and contacts with occupational therapy in other countries. It was composed of: Miss Elizabeth Clark, who had worked with the U.S. Army in Germany and had been assistant director of the Liverpool School of Occupational Therapy, Mrs. Martha Jackson Lilley, who was principal of the Dorset House School of Occupational Therapy in England from 1934 to 1938, and one of the early members of the association in England, Miss Marjorie Fish, who for two years was director of the occupational therapy school in Australia, Miss Helen S. Willard, as chairman of the education committee and because of the student exchange for clinical training with English schools as developed by the Philadelphia School of Occupational Therapy, Miss Wilma West, as executive-secretary, Mr. Conrad Gable, who had worked in Austria with a team sent through the United Nations, and myself as chairman.

This committee studied carefully the proposals resulting from the Stockholm meeting and prepared a rough draft of a constitution for the guidance of the delegates from the A.O.T.A. This draft was sent to each Board of Management member of the A.O.T.A. prior to the mid-year meeting in March, 1952, for their comments and suggestions. At this meeting Miss Spackman was formally appointed delegate and Miss Willard as alternate to represent the A.O.T.A. at the preparatory commission.

Miss Willard and I attended the preparatory meeting of the World Federation of Occupational Therapists, April 7-10, 1952, in Liverpool, England. It was a most interesting meeting in which much was accomplished. There were representatives from the following occupational therapy associations:

Canada	Miss Nancy Bushall, substitute alternate
Scotland	Miss Margaret Fulton, delegate
	Miss Fitch, alternate
England	Mrs. Glyn Owens, delegate
	Miss Grizel MacCaul, alternate
Sweden	Miss I. Hildebeck, delegate
Denmark	Miss Ingrid Pahlsson, delegate
South Africa	Miss Dorothy Stedman, substitute alternate
U.S.A.	Miss Clare S. Spackman, delegate
	Miss Helen S. Willard, alternate

Australia, Israel and New Zealand were represented by written comment.

A draft of the constitution and standing orders was compiled. This has been sent to each association for approval. In addition, tentative minimum standards of education were worked out because of the urgent request from two of the associations. Organization and individual membership forms and tentative standards were developed.

The World Federation of Occupational Therapists was formally voted into being as of April 7, 1952. Miss Fulton, who represented Scotland, was elected president; Miss Crawford, of Canada, first vice president; Miss Pahlsson, of Denmark, second vice president; Mrs. Glyn Owens, of England, secretary-treasurer; Miss Spackman, of the U.S.A., assistant secretary-treasurer. The following chairmen of committees were also appointed: Education, Miss Willard; International Relations, Mrs. Owens; Legislation, Miss Fitch; Membership, Miss Fulton, Mrs. Owens, Miss Bushall, Miss Hildebeck; Congresses, Miss Spackman.

The financial support of the Federation was discussed at length. It was finally agreed to try out the following procedure: To make a drive for voluntary contributions from all occupational therapists, their friends, and interested lay persons. These can be in two forms: (1) By becoming individual members, fee $3.00 per year; or, contributing members, minimum fee $6.00 per year. (2) By an outright contribution to the Association. There will also be an organization membership fee of $15.00 for those associations with membership under 750, and $30.00 for associations over 750. It is hoped that in five years we can raise $15,000 among the approximately 5000 occupational therapists in the world. It will mean a contribution of approximately $3.00 total per therapist over a five-year period. It may be possible for us to raise even more here as our salaries are so much higher than those in other countries. It may also be possible for us to get larger gifts from lay persons who have been so much interested in supporting occupational therapy in the United States.

To avoid difficulty in transfer of funds from the sterling and dollar areas a treasurer and an assistant treasurer were appointed and two bank accounts will be maintained. Any contributions or applications for contributing memberships here should be sent to me as assistant treasurer for the dollar area. Applications for individual members should be approved first in the A.O.T.A. office to assure that the person is a member in good standing of the A.O.T.A. Membership application forms will be available shortly.

The completed constitution and the standing orders were sent to the members of the House of Delegates and the Board prior to this meeting for their study.

The Board approved the membership of the A.O.T.A. in the World Federation at its meeting, August 9, 1952.

It is hoped that it will be possible to hold an international meeting in the near future, possibly in 1954. It is the plan of W.F.O.T. to hold a Council or Board meeting every two years and to have a Congress every fourth year. It is recognized that no association, including the A.O.T.A., can ever hope to afford to pay the expenses of the delegate or alternates, and therefore provision has been made to

send a substitute-alternate to such meetings when necessary. It will thus be possible to utilize the services of those of our members who are indulging in foreign travel.

Respectfully submitted,
CLARE S. SPACKMAN, O.T.R.,
Chairman.

COMMITTEE ON OCCUPATIONAL THERAPY IN PSYCHIATRY

The Board is already aware that this chairman has appointed regional chairmen as a modus operandi for activating psychiatric occupational therapy throughout the country. Although there have been distinct disadvantages in the resulting relay system, with four of the chairmen suffering major illnesses in the course of the year, it appears the best way to reach any considerable number of workers in the field without special secretarial service, and while the chairman is employed on a demanding position. It also encourages initiative through a spread of responsibilities, and facilitates the development of local groups.

All but one of these chairmen have been successful in contacting a considerable portion of the psychiatric O.T.'s in their areas. Four areas reported groups of O.T.'s sufficiently interested and geographically located so that they can undertake projects for the coming year.

The major activity for the year, as reported in March, has been preparation, distribution, and partial correlation of a questionnaire. The distribution process, through regional chairmen, has not been too satisfactory, and is still going on. There have been many criticisms of the questionnaire, and it has aroused some antagonism. One-hundred-eighty have been returned to the national chairman up to this time. One-hundred-fifty of these have been partially correlated, making some very interesting data available, and providing the basis for further studies on the part of the committee. One section contains considerable information on educational matters, and it is proposed to turn this data over to the educational committee. Concern expressed on matters of recruitment and legislation is such that the chairman envisages the possible preparation of recommendations on these subjects for referral to the appropriate committees. Research is also prominently mentioned, and it is hoped that this committee may provide the interchange of ideas and critical evaluation which will generate research projects suitable for referral to the special studies committee for approval.

An organizational problem, which is clearly brought out by the questionnaire, is that some of the most interested individuals are in isolated areas, so that the vital interchange of ideas becomes a major problem. Ninety-six of the one-hundred-fifty individuals whose opinions have been correlated expressed willingness to spend as much as two dollars on a bulletin in this field. Fourteen of them were willing to spend four dollars. While the problems of producing such a bulletin are such that it does not seem practical at this time, we must give it serious consideration for the future as the only practicable way of meeting the communication problem. The bulletin desired would in no way be a competitor with A.J.O.T. It would provide opportunity for candid comment, present proposed research for criticism, announce and report on meetings of allied groups, and provide an exchange of information on special problems. It could be candid because of a limited circulation, and should provide a training experience for A.J.O.T. writers.

The major accomplishment of the committee has been relationship with psychiatrists. An exhibition financed by the New York Occupational Therapy Association was planned and prepared by the New York-Philadelphia regional committee. This was exhibited at the American Psychiatric Association convention at Atlantic City, and brought forth expressions of interest, questions and favorable comments from a considerable number of psychiatrists. While this exhibit is available from the New York Association for the cost of transportation, that cost is sufficiently high to limit its use. Consequently it is proposed to make plans available for the use of those who wish to duplicate the exhibit. The chairman feels it desirable to have a sub-committee on exhibitions to plan other effective publicity of this type.

The New York-Philadelphia division of the committee also arranged the occupational therapy meeting at Atlantic City coordinated with the American Psychiatric Association meeting. As a result of its publicity more than one-hundred O.T.'s attended the A.P.A. round table on O.T. The spirit and effective interchange of ideas at this meeting was such that several psychiatrists called it a landmark in the maturation of psychiatric O.T. In addition to gaining medical support, this and the special O.T. sessions served to stimulate O.T.'s, and may act as a beginning for that formulation of concepts expressed as one of the aims of the committee.

As a representative of the A.O.T.A., the chairman has corresponded with the editors of the *American Journal of Psychiatry*, and of *Mental Hospitals* concerning the therapeutic role of O.T. An article has been written, and another is in process of preparation, for publication in these journals.

The chairman feels, however, that one of the most effective means of establishing good professional working relationships is through individual contacts with psychiatrists, psychologists, social workers, pychiatric nurses and the various specialist in the field of patient activities. The chairman is fortunate in having had the opportunity to visit 24 hospitals during the past year, and to have had extended contacts with superintendents and other key individuals. She has found that, while they are frequently pointedly uninterested on first contact, they respond with interest to carefully directed questions, and not infrequently express a change in viewpoint as a result of the contact. It is felt that much could be accomplished in the improvement of inter-professional relations through the indirect approach stressing patient welfare.

A meeting of the committee on Sunday, August 10, at the Hotel Schroeder was attended by 24 workers from the field of psychiatric O.T. Written reports were given from the areas not represented. After some discussion it was voted by the group to recommend the continuance of the committee on its present basis for another year. If the Board will approve this, the chairman hopes to make further progress in meeting the aims expressed for the committee through the establishment of sub-committees.

Respectfully submitted,
Elizabeth P. Ridgeway, O.T.R.,
Chairman.

REGIONAL CHAIRMEN

Committee on O.T. in Psychiatry

New England Area (Maine, Vt., N.H., Conn., Mass., R.I.)
Miss Inez Hunting, O.T.R.

New York-Phila. Area (East. N.Y., N.J., Del., East Pa.)
Mrs. Jay Fidler, O.T.R.

Tri-state Area (N.C., D.C., Md., Va.)
Miss Beatrice Gold, O.T.R.

Chicago-Milwaukee Area (Wis., Ill., Ind., Minn., Ia.)
Mrs. Mildred Trabert, O.T.R.

Northwestern Area (N. and S.D., Ore., Wash., Idaho, Mont.)
Miss Myrla Smith, O.T.R.

Detroit Area (Mich., Ohio, West. N.Y.)
Miss Marion Holton, O.T.R.

Cincinnati Area (Ky., W.Va., Ohio, West. Pa.)
Miss Marguerite McDonald, O.T.R.

Oklahoma-Texas Area (La., Ark., Okla., Tex., N.M.)
Miss Mary Alice Coombs, O.T.R.

Southeasten Area (S.C., Ga., Tenn., Fla., Miss., Ala.)
Miss Ann Fraser, O.T.R.

California Area (Nev., Ariz., Calif.)
Mrs. James Taggert, O.T.R.

Mountain States Area (Colo., Wyo., Utah)
Lt. Lois Sargent, O.T.R.

Kansas Area (Kan., Mo., Neb.)
Miss Alice Ingram, O.T.R.

Hawaiian Area
Miss Kay Imamura, O.T.R.

Pueerto Rican Area
(No appointment at present)

PERMANENT CONFERENCE COMMITTEE

As permanent conference chairman it is a pleasure to welcome you to the 35th annual conference of the American Occupational Therapy Association. The members of the Wisconsin Occupational Therapy Association under the expert guidance of Mrs. Lucie Murphy, are to be highly commended for the excellent work they have done in planning not only the technical phase of the program but also the extra-curricular activities and entertainment. As you know, it is almost impossible to include all phases in each area of occupational therapy in one annual conference program, but I feel confident that each one of us will find the sessions we choose to attend interesting and informative. I am sure we will return to our respective positions with renewed enthusiasm.

It is an established policy of your National Association to schedule future conferences at least two years in advance. Possibly some members are not aware of discussions that have taken place in meetings of both the House of Delegates and Board of Management regarding the time of year most convenient to schedule the annual conference in order not to conflict with the opening of colleges or universities or the changing of clinical affiliations. At the annual conference in 1948 it was recommended that an effort be made to establish the third week in October each year as conference week. Of course, this policy must remain flexible in order to meet any emergencies that might arise such as was the case this year.

It is a responsibility of the permanent conference committee to secure information regarding hotel facilities from hotels in metropolitan areas as well as resort areas to present to the Board of Management to assist them in the final selection of a conference site. If any members have any suggestions as to possible sites please let me know.

The 1953 annual conference will be held in Houston, Texas. Already the Texas Association is hard at work under the able direction of Mrs. Lucile Lacy as the local general chairman. Mrs. Fannie Vanderkooi has been appointed program chairman for the institute. Miss Mary Britton has been designated as program chairman for the conference.

In 1954 the annual conference will be held in Washington, D.C., with headquarters at the Shoreham Hotel. The District of Columbia O.T. Association and the Virginia O.T. Association will work together in conference planning.

I want to call your attention to the commercial exhibits. As you know, the commercial exhibits have become an important part of our conference. I want to express my sincerest appreciation to Mr. Howard Tanner, Deck Officer for The Ship, for his assistance in working out problems, and in the formulation of policies for commercial exhibits. Also, I want to thank Mr. Joe Larson, for assisting Mr. Tanner in planning The Ship's Party. Also, I would like to urge each occupational therapist to patronize the firms participating in the commercial exhibit. They are supporting your National Association by exhibiting with us each year and in turn we should gve them our full support whenever possible.

Let me remind everyone that in order to qualify for the drawing of prizes at The Ship's Party tomorrow night, the exhibit card given to you at the time of registration must be punched by each exhibitor as you visit their display.

Respectfully submitted,
Josephine Davis, O.T.R.,
Chairman.

REPORT OF LEGISLATIVE AND CIVIL SERVICE COMMITTEE

The activities of the legislative and civil service committee, for the first half of the year, appeared in full in the minutes of the mid-year meeting of the Board of Management (A.J.O.T., Sept.-Oct., 1952).

Miss Naida Ackley, whose resignation as chairman of this committee had recently been accepted, presented the report to the membership covering the last half of the year: The Connecticut O.T. Association has established an advisory council to help them in their legislative matters. These five members include a doctor of physical medicine, hospital supervisor, hospital administrator, public relations and press representatives. The Connecticut Association does not plan any further initiative or approach relative to licensing, but they are preparing a bill to be ready if necessary.

Eighteen state representatives were present at the 1952 conference meeting of the legislative committee and recommended: (1) Re-evaluation of the definition of occupational therapy relative to objectives and scope. Too broad for justification at present. (2) Need for job classifications in state and other institutions relative to problem of professional personnel shortage. (3) Advise regarding use of term Rehabilitation Therapies vs. O.T. Unfortunate misinterpretation by state legislatures.

Auditory Mechanism . . .

(*Continued from page* 4)

had special speech training and, of course, he has not ever heard speech. Examination has shown that in the so-called "deaf-mute" the speech and voice mechanisms are almost invariably intact. Even if an individual has acquired speech, and then has lost his hearing before reaching his sixth year, he may still lose his speech altogether. After the sixth year he will usually have imperfect or monotonous speech.

Only with special education by highly trained teachers may a person without hearing learn to speak. If he has some hearing, but is weakest in the area of high-pitched sounds, he will have great difficulty in distinguishing consonants, and will have trouble in articulating them. Weakness in the low-pitched area will cause less difficulty as it involves the vowels mostly. Furthermore there are individuals whose hearing is adequate but whose memory span is poor, i.e., they can remember only a few syllables of a sentence. Such persons may have a cluttering type of speech. Patient training

by a therapist may improve this condition to a considerable extent.

It should be observed that very often persons with a conduction type of hearing loss will tend to speak in very low tones while those having a perception deafness will speak quite loudly.

This discussion has touched very briefly upon the structure, the functions and the diseases of the auditory apparatus, a study worthy of many volumes. It is suggested that those working with the deaf or hard of hearing enrich their background by reference to the many excellent books and articles for layman and professional which are available, two of which are listed below for convenience. Such knowledge is essential to the proper handling and rehabilitation of patients with hearing and speech problems.

SUGGESTED READINGS

Davis, Hallowell, *Hearing and Deafness.* Murray Hill Books, N.Y., 1947.

Fowler, Edmund P. Jr. *Medicine of the Ear.* Thos. Nelson and Son, N.Y., 1947.

Book Reviews

CHILD'S BOOK OF SEWING
Jane Chapman, Author
Greenberg: Publisher
201 East 57th Street
New York 22, N.Y. 1951

Reviewed by: Wanda Misbach Edgerton, O.T.R.

Written and illustrated so that the child herself, can read and understand i.t Four simple stitches are tried out first on a Sewing Stitch Card. These are then adapted to use in the making of simple articles of felt with additional suggestions to stimulate the imagination in going on to others of the child's own creation. Directions are clear and simple, yet give a great deal of information too, for instance on the sizes of needles, how to take care of scissors etc. The illustrations are clear, attractive in two colors and could almost be followed without the text. Prepared for the child of seven or thereabouts, there is enough of substance here to be of interest up to eleven or twelve or beyond. If you work with children you could probably use more than one copy.

YOUR CRAFT BOOK
Louis V. Newkirk, Ph.D.
Director of Industrial Arts Education
Chicago Public Schools
and
LaVada Zutter, M.A.
Commercial Illustrator and Former Teacher
of Arts and Crafts
Chicago Public Schools
International Book Company, Scranton, Pennsylvania

Reviewed by: Wanda Misbach Edgerton, O.T.R.

In five years this book has gone through three printings, which is some evidence that the public has found it useful. In its two hundred plus pages there are ideas and plans for Toys and Games, Holidays, Masks and Puppets, Needle and Thread, Water and Clay, Music Makers and Gifts. The tools required are simple and the materials inexpensive and readily obtainable. The text is written so that a child may enjoy and understand it, but the illustrations are so clear that printed directions are practically unnecessary.

CLASSIFIED ADVERTISING

Classified advertising accepted for POSITIONS WANTED and POSITIONS AVAILABLE only. Minimum rate $3.00 *for* 3 *lines; each additional word ten cents. (Average* 56 *spaces per line). Copy deadline first of each month previous to publication.*

POSITIONS AVAILABLE

Responsible positions for progressive occupational therapists in New York State Department of Health tuberculosis hospitals. Liberal vacation, holidays and sick leave. Present salary $3,571-$4,372. Write Supervisor of Occupational Therapy, Division of Tuberculosis Control, 28 Howard Street, Albany 7, New York.

Wanted: Registered occupational therapist supervisor, $345 per month; also one occupational therapist assistant, $230 per month. Apply: Dr. Eugene E. Elder, Superintendent, Youngstown Receiving Hospital, Youngstown, Ohio.

Connecticut, Newtown. Positions available for occupational therapists and senior occupational therapists. Well equipped treatment units; new building plans progressing; good living facilities. Write to occupational therapy department, Fairfield State Hospital.

Occupational Therapists for large psychiatric hospital located in New England. Progressive, all-inclusive program for patients. Student affiliations with excellent educational program. Modern home, good food. Maintenance

optional. Liberal retirement plan and illness policy. Paid vacations and holidays. Write to Director of Occupational Therapy, Norwich State Hospital, Norwich, Connecticut.

Registered occupational therapist for immediate employment in rehabilitation of neurological and orthopedic children and adults, under direct supervision of physiatrist. Should have supervisory ability. Salary range from $3300-$4500. Paid vacation, sick leave, and uniform laundry furnished. Write: Institute of Physical Medicine Rehabilitation, 619 N. Glen Oak Ave., Peoria, Illinois.

Occupational therapist for 400 bed general hospital with active department. Write Manager, St. Luke's Hospital, Bethlehem, Penna.

Immediate opening for staff occupational therapist in expanding orthopedic department. Correlation of physical therapy and occupational therapy stressed. Generous salary, vacation, sick leave and retirement plan. Apply: Chief of Occupational Therapy, Delaware Curative Workshop, Inc., 16th and Washington Streets, Wilmington, Delaware.

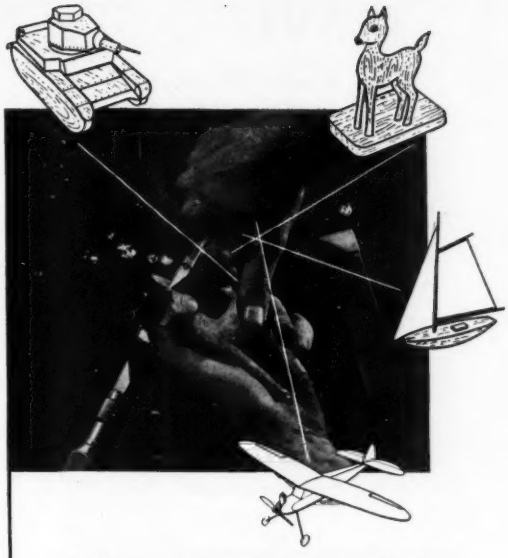
Wanted: Occupational therapist for work in cerebral palsy treatment center. Good salary. Good working conditions. Scholarship available for additional training in cerebral palsy. Program directed by diplomate of the American Board of Physical Medicine. Write Herman L. Rudolph, M.D., 400 North Fifth Street, Reading, Pennsylvania.

Qualified occupational therapist to work in occupational therapy and rehabilitation program in 500 bed hospital. Work supervised by specialist in physical medicine and rehabilitation. Good starting salary, vacation, sick leave and retirement benefits. Write Herman J. Bearzy, M.D., Director of Physical Medicine and Rehabilitation, Miami Valley Hospital, Dayton, Ohio.

Exceptional opportunity for 2 registered therapists in cerebral palsy clinic. Vacation, holidays and sick leave. Lunch supplied. Modernly equipped department. Pleasant working conditions. Contact Mrs. John Keefe, Cerebral Palsy Clinic, Medical Center, Jersey City, N.J., De-3-5861.

Registered occupational therapist to direct the department and supervise training of affiliating students. Direct letter giving full outline of experience and references to Childrens Hospital, 4614 Sunset Blvd., Los Angeles 27, California.

Position open for a registered occupational therapist in the private practice neuropsychiatric department of the Hertzler Clinic and Halstead Hospital, Halstead, Kansas. Active treatment and training center—40 bed N.P. Write Mrs. Marjorie Clark, O.T.R., Halstead Hospital, Halstead, Kansas.



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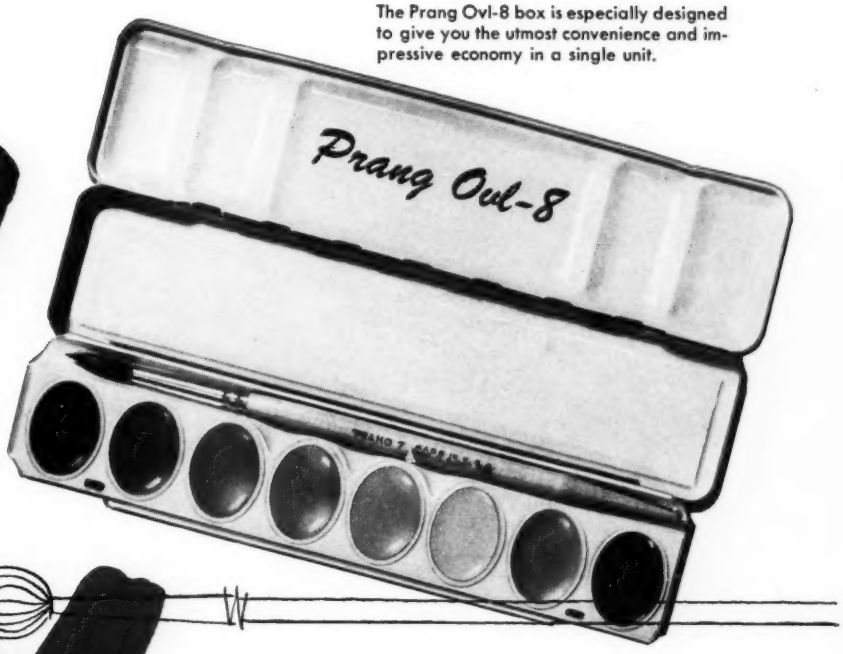

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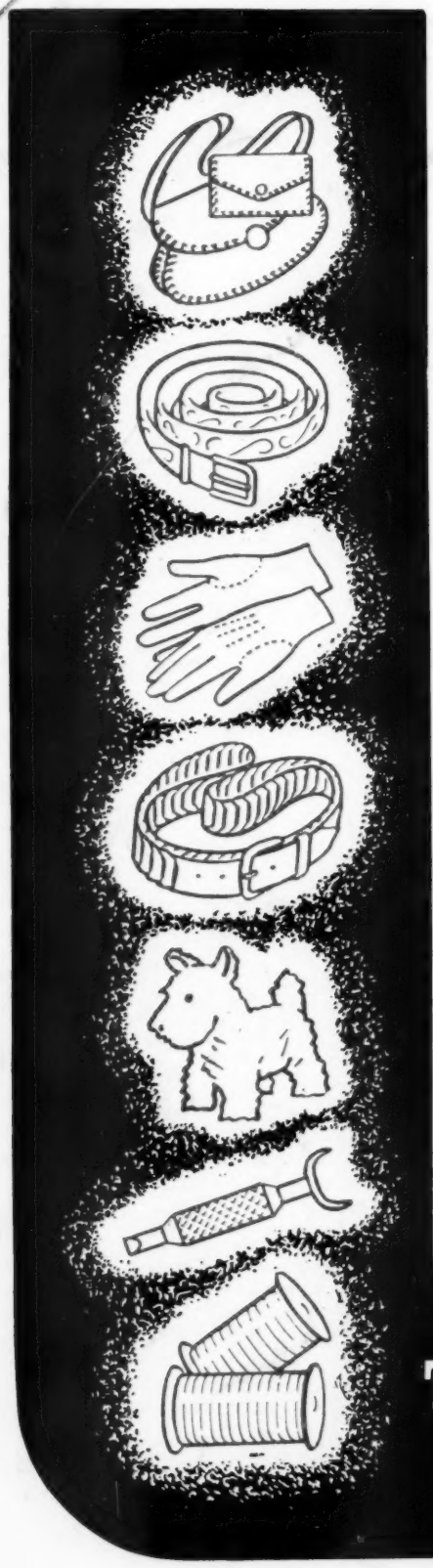

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